

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06204

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06204

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 50 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 01-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital			d. STREET ADDRESS Route 2, Williams Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Clyde Middle A. Last Ballou			4. DATE OF DEATH Month May Day 19 Year 1966		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 17, 1888-77 yrs.		9. AGE (In years lost birthday) IF UNDER 1 YEAR: Months 11 Days 19 IF UNDER 24 HRS.: Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Auburn, Kansas	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Unknown		
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			
16. SOCIAL SECURITY NO.		17. INFORMANT John E. Ballou, Cumberland, Md. Son			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot of Head DUE TO (b) (Self-Inflicted) DUE TO (c) 976 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH 50 mins.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22. DATE SIGNED May 19, 1966		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county) Rt. 9 Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 22, 1966		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	
23d. LOCATION (City or Town) Cumberland, Md.		(County)		(State)	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR MAY 24 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

06205

CERTIFICATE OF DEATH

06201

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN lb 53 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 516 WASHINGTON ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MORRIS BARON		4. DATE OF DEATH Month Day Year MAY 10 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 19, 1879 9. AGE (In years last birthday) yrs. 87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) POLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JACOB BARON		14. MOTHER'S MAIDEN NAME BATHSHEBA H. BLOOM	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT MEMORIAL HOSPITAL Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Severe hemorrhages, constant DUE TO (c) Extensive Ca of blood Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 1 Year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic R.V.D. Multiple Complication			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) 5-10
21. I certify that (I) (this hospital) attended the deceased from March 15, 19:30 to P.M. 66, 1966 , that (I) (we) last saw the deceased alive on 5-10-66 19__, and that death occurred at __ M, from causes and on the date stated above.			
22a. SIGNATURE Valdes		22b. DATE SIGNED 5-11-66	
22c. PHYSICIAN'S NAME (Type) DR. JOSE L. VALDES		22d. ADDRESS ALGONQUIN HOTEL, CUMB. MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/12/66	23c. NAME OF CEMETERY OR CREMATORY East View Cem.	23d. LOCATION (City or Town) (County) (State) Cumberland Allegany MD
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. MD.		25a. REC'D BY REGISTRAR MAY 13 1966 25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06206

CERTIFICATE OF DEATH

06202

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 41 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hyndman, Pa.		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William H Bartgis		4. DATE OF DEATH Month Day Year May 9 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/6/89
9. AGE (In years lost birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Rubber Worker		10b. KIND OF BUSINESS OR INDUSTRY Kelly-Springfield	
11. BIRTHPLACE (County & State, or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael D Bartgis		14. MOTHER'S MAIDEN NAME Martha Ellen Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-05-5968	
17. INFORMANT Donald W. Bartgis		18. Address Patient's chart Routel, Bx147 Hyndman Pa.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic Poisoning DUE TO (b) Acute Renal Failure DUE TO (c) Acute Hemorrhagic Cystitis & Diverticulitis			
INTERVAL BETWEEN ONSET AND DEATH 4 Wk. 4 Wk. 3 Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombophlebitis with pulmonary embolism, Diabetes mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 26 , 1966, to May 9 , 1966, that (I) (we) last saw the deceased alive on May 9 , 1966, and that death occurred at 12:50 PM from causes and on the date stated above.			
22a. SIGNATURE James F. Hallinan		22b. DATE SIGNED 5-11-66	
22c. PHYSICIAN'S NAME (Type) Dr. James Hallinan		22d. ADDRESS 1140 Bedford Street, Cumberland, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 12, 1966	
23c. NAME OF CEMETERY OR CREMATORY Mt. Savage Methodist Cem.		23d. LOCATION (City or Town) (County) (State) Mt. Savage, Allegany Md	
24. FUNERAL DIRECTOR John J. Hofer		25a. REC'D BY REGISTRAR MAY 12 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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30830

OFFICE OF THE ATTORNEY GENERAL

30830

RECEIVED

NOV 10

1966

TO THE ATTORNEY GENERAL

FROM

DATE

BY

FOR

FILE

RE: [illegible]

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RECEIVED MAY 12 1966

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06207

06207

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. LENGTH OF STAY IN 1b <u>20 MINUTES</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SACRED HEART HOSPITAL</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRESAPTOWN* CUMBERLAND</u>	
3. NAME OF DECEASED (Type or print) <u>MOSEY MOSBY</u>		f. STREET ADDRESS <u>ROUTE 5, WINCHESTER ROAD</u>	
4. DATE OF DEATH <u>MAY 23 19 66</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 2, 1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONSTRUCTION STEEL WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
13. FATHER'S NAME <u>FRANCIS JOSEPH BOOR</u>		14. MOTHER'S MAIDEN NAME <u>ALMA ELLIOTT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>216-07-8820</u>	
17. INFORMANT <u>KATHRYN WOODRUM BOOR</u>		Address <u>CRESAPTOWN, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		22. DATE SIGNED <u>MAY 23, 1966</u>	
EXAMINER'S NAME (Type) <u>DR. BENEDICT SKITARELIC, M.D.</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>MAY 26, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cook's Mill Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Bedford County Pa.</u>
24. FUNERAL DIRECTOR <u>John J. Hafer</u>		25a. REC'D BY REGISTRAR <u>MAY 25 1966</u>	
ADDRESS <u>230 BALTO AVE., CUMBERLAND, MD</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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5032

James G. Thompson 1881-1914

FOR STATE HEALTH DEPT.

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VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #8 & 9 Film #G377 5/2/66 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06208

06204

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 45 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11 Altamont Terrace				d. STREET ADDRESS 11 Altamont Terrace			
3. NAME OF DECEASED (Type or print) First Oliver Middle Selby Last Bosley				4. DATE OF DEATH Month May Day 21 Year 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27, 1887	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 7 Days 18	IF UNDER 24 HRS. Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Telegrapher		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Barton, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Amos Bosley				14. MOTHER'S MAIDEN NAME Grace Liller			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 219-03-8287		17. INFORMANT Address Mrs. Virginia Cleo Bosley, Cumberland Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) -- (c)							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED May 21, 1966	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 24, 1966		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR MAY 24 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge	

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MAY 1 1966
Page 10 of 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06209

CERTIFICATE OF DEATH

06205

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u>			
c. LENGTH OF STAY IN 1b <u>76 Years</u>				d. STREET ADDRESS <u>301 Maryland Ave.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>301 Maryland Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Bothwell</u> Last <u>Bothwell</u>				4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 15, 1890</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brakeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Allegany, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hugh Bothwell</u>				14. MOTHER'S MAIDEN NAME <u>Ethyl E. Sigler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Mary Hopkins</u>		Address <u>Luke, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric Rectum</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>66</u> , to <u>May 1st</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>April 19</u> , 19 <u>66</u> , and that death occurred at <u>59</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>James H. Wolverton, Sr.</u>				22b. DATE SIGNED <u>5/1/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>James H. Wolverton, Sr.</u>				22d. ADDRESS <u>For Mayor, Pleasant W. H.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/4/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Westernport, Md.</u>	
24. FUNERAL DIRECTOR <u>E. J. Bual</u>				25a. REC'D BY REGISTRAR <u>MAY 3 1966</u>			
ADDRESS <u>Westernport, Md</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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NOV 3 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
06210					CERTIFICATE OF DEATH					06206									
1. PLACE OF DEATH a. COUNTY Allegheny b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 01-1 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 209 Washington St.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegheny c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 209 Washington					6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Rose Callaghan Bowen					4. DATE OF DEATH Month Day Year May 8 1966														
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 13, 1880		9. AGE (in years last birthday) 85 yrs.		F UNDER 1 YEAR Months Days Hours Min.		H UNDER 24 HRS. Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY —					11. BIRTHPLACE (County & State, or foreign country) Altoona, Penna.					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME James W. Callaghan					14. MOTHER'S MAIDEN NAME Ellie Dorsey Callaghan														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —					16. SOCIAL SECURITY NO. —					17. INFORMANT Mrs Robert M. Bruce					Address Cumberland, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lympho-Sarcoma retro- 2001 DUE TO peritoneal & liver metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —										INTERVAL BETWEEN ONSET AND DEATH 3 days									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Oper (gastro-jejunostomy 2/23/66 - Sac. Ht. Hosp.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NO					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —					20f. (City or town) (County) (State) —				
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.																			
22a. SIGNATURE A. J. Mirkkin										22b. DATE SIGNED —									
22c. PHYSICIAN'S NAME (Type) Dr. A. J. Mirkkin										22d. ADDRESS 115 So. Centre St. Cumberland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 5/11/66					23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem					23d. LOCATION (City, town or county) (State) Cumberland Md				
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb Md										25a. REC'D BY REGISTRAR MAY 12 1966					25b. REGISTRAR'S SIGNATURE Charles Judge				

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00200

10/1/50

10/1/50

06211

CERTIFICATE OF DEATH

06207

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE WEST VIRGINIA b. COUNTY MINERAL COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 HRS. 3 MIN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS STAR RT.#1 BOX 56	
3. NAME OF DECEASED (Type or print) First Noah Middle W. Last BOYCE		4. DATE OF DEATH Month MAY Day 18 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 18, 1966
9. AGE (In years last birthday) Yrs.		10. IF UNDER 1 YEAR Months 2 Days 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NOAH W. BOYCE		14. MOTHER'S MAIDEN NAME THELMA KAYE ARNOLD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxemia - 7625 DUE TO Immature (23 wks preg.) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19__	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19__, to _____, 19__, that (I) (we) last saw the deceased alive on _____, 19__, and that death occurred 2:02 P.M. from causes and on the date stated above.			
22a. SIGNATURE Merico Valde		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Merico Valde, M.D.		22d. ADDRESS Cumberland, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May, 20, 1966	23c. NAME OF CEMETERY OR CREMATORY Potomac Valley Memo. Pk	23d. LOCATION (City or Town) (County) (State) Keyser, W. Va.
24. FUNERAL DIRECTOR Allen M. Natun		25a. REC'D BY REGISTRAR MAY 23 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

WEST VIRGINIA
MINERAL COUNTY
CUMBERLAND
HILLCREST

2 HRS. 3 MIN. REYSER
STAR RT. 1 BOX 22
MEMORIAL HOSPITAL

BOYCE V. V.
MAY 1, 1906
NAME WHITE

CUMBERLAND, MD.
R. L. KAYE ARNOLD
BOYCE V. V.

MEMORIAL HOSPITAL, CUMBERLAND, MD.

MAY 1, 1906

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

06212

CERTIFICATE OF DEATH

06208

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 1112 BEDFORD STREET	
3. NAME OF DECEASED (Type or print) (MAGGIE) MARGARET E. BRADY		4. DATE OF DEATH Month MAY Day 23 Year 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 12, 1886
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Penna MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE ESHELMAN		14. MOTHER'S MAIDEN NAME RACHEL RITCHIE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-18-2823	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4500 IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO (b) Generalized arteriosclerosis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 2 d	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-22 , 19 66 , to 5-23 , 19 66 that (I) (we) last saw the deceased alive on 5/23 19 66 , and that death occurred at 3:15 AM from causes and on the date stated above.			
22a. SIGNATURE William P. James		22b. DATE SIGNED 5/26/66	
22c. PHYSICIAN'S NAME (Type) WILLIAM P. JAMES, M.D.		22d. ADDRESS 441 N. CENTRE ST., CUMBERLAND, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/26/66	
23c. NAME OF CEMETERY OR CREMATORY Everett Cemetery		23d. LOCATION (City or Town) (County) (State) Everett Penna	
24. FUNERAL DIRECTOR H. Lee Silcox		ADDRESS Cumberland Maryland 21502	
25a. REC'D BY REGISTRAR MAY 31 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

06202

0621

CERTIFICATE OF STATE

ALLIANCE

CONGRESSIONAL

1112 RECORD STREET

MAY 23 1968

JUNE 12 1968

GEORGE ESMELMAN

THE HOSPITAL CONGRESS

1112 RECORD STREET

1112 RECORD STREET

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
06218																			
06209																			
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONA CONING					c. LENGTH OF STAY IN 1b 2 YEARS					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) KYLE NURSING HOME					d. STREET ADDRESS N. MECHANIC ST.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First MINNIE Middle ALICE Last CANAN					4. DATE OF DEATH Month MAY Day 25 Year 1966														
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 24, 1883		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 01 Days 11		IF UNDER 24 HRS. Hours 00 Min. 00							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE					10b. KIND OF BUSINESS OR INDUSTRY OWN HOME					11. BIRTHPLACE (County & State, or foreign country) TERRA ALTA, W. VA.					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME BENJAMIN BUCKLEW					14. MOTHER'S MAIDEN NAME VIRGINIA BUCKLEW														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. NONE					17. INFORMANT Anita Canan					Address Cumberland, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Atherosclerotic CV disease DUE TO (c) 										INTERVAL BETWEEN ONSET AND DEATH 2 wks years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1964 to May 25, 1966 , that (I) (we) last saw the deceased alive on May 9, 1966 , and that death occurred at 9 A M , from the causes and on the date stated above.																			
22a. SIGNATURE L.R. Miles Jr					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED 5-26-66									
22c. PHYSICIAN'S NAME (Type) L.R. MILES JR, M.D.					22d. ADDRESS LONA CONING														
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE THEREOF MAY 28, 1966					23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK					23d. LOCATION (City, town or county) (State) CUMBERLAND, MD.				
24. FUNERAL DIRECTOR BYRON KIGHT					ADDRESS CUMBERLAND, MD.					25a. REC'D BY REGISTRAR JUN 6 1966					25b. REGISTRAR'S SIGNATURE Charles Judge				

6032

41330

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06214

06210

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O. A. Memorial Hospital				d. STREET ADDRESS 17 Wempe Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Simon K. Carroll				4. DATE OF DEATH Month Day Year May 5 19 66			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 12, 1895	
9. AGE (In years lost birthday) yrs. 71		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Water Supt.		10b. KIND OF BUSINESS OR INDUSTRY Municipal		11. BIRTHPLACE (State or foreign country) Midland, Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME James P. Carroll			
14. MOTHER'S MAIDEN NAME Margaret Kenny				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes			
16. SOCIAL SECURITY NO. 215-36-8778				17. INFORMANT Address Mrs. Margaret C. Carroll, Cumberland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO (b) Coronary Sclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH Sudden ---
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> May 5, 1966 22. DATE SIGNED			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				Address (Street, city, town, or county) Rt. 9 Cumberland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 9, 1966		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE MAY 10 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
06215		CERTIFICATE OF DEATH	
06211			
1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL CUMBERLAND MD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MISS ELIZABETH CASSEN		4. DATE OF DEATH Month MAY Day 19 Year 66	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/22/1889	
9. AGE (In years) 76 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN HENRY CASSEN		14. MOTHER'S MAIDEN NAME CAROLINE BARTH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-16-5789A	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Terminal Cardiac Failure DUE TO (b) Myocardial Infarction, atherosclerosis, arteriosclerosis DUE TO (c) Arteriosclerotic Cordvax. disease INTERVAL BETWEEN ONSET AND DEATH 24 hours 5 days 20 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 14 May, 1966 , to 19 May, 1966 , that (I) (we) last saw the deceased alive on 19 May, 1966 and that death occurred at 10:15 AM on the date stated above.			
22a. SIGNATURE Dr. W.A. Van Ormer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. W.A. VAN ORMER		22d. ADDRESS 122 S. CENTRE ST. CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/21/66	
23c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Alleg Maryland	
24. FUNERAL DIRECTOR Ruth E. Silcox Cumberland Maryland 21502		25a. REC'D BY REGISTRAR MAY 23 1966	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

06319

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MARYLAND

MARYLAND

CUMBERLAND

CUMBERLAND

2 DAYS

CUMBERLAND MD. 433 COLUMBIA ST.

MERIDIAN HOSPITAL

MRS. MISS ELIZABETH M. TAYLOR

Female White

CUMBERLAND, MD.

CAROLINE PARK

HENRY CASSER

MERIDIAN HOSPITAL, CUMBERLAND, MD.

133 S. 2nd St. CUMBERLAND, MD.

DR. W. A. VAN DUSEN

MAY 21 1961

TO DIRECTOR, DISTRICT OF COLUMBIA
FROM [illegible]
SUBJECT: [illegible]

06216

CERTIFICATE OF DEATH

06212

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
c. LENGTH OF STAY IN 1b 1 Week		d. STREET ADDRESS B.T. # 2 BOX 166	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NELLIE MAY CHARLTON		4. DATE OF DEATH MAY 8 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-11-1907
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR: Months 8 Days 166	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Hospital Employee		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES HONNBROOK (D)		14. MOTHER'S MAIDEN NAME RENA STRAWSER (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-28-9498	
17. INFORMANT PT'S CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4/16x DUE TO Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Rheumatic Heart Disease (c) 10 days 15 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 wks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 5, 1951 , to May 8, 1966 that (I) (we) last saw the deceased alive on May 8, 1966 , and that death occurred at 5/8/66 M, from causes and on the date stated above.			
22a. SIGNATURE Clayton Durrett M.D.		22b. DATE SIGNED 5/8/66	
22c. PHYSICIAN'S NAME (Type) DR. DURRETT, M.D.		22d. ADDRESS 236 VIRGINIA AVE. CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/11/66	
23c. NAME OF CEMETERY OR CREMATORY Mt Pleasant Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR Ruth E. Silcox ADDRESS Cumberland Maryland 21502		25a. REC'D BY REGISTRAR MAY 12 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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EXTRACT OF CHAIN

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06217

CERTIFICATE OF DEATH

06213

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 14 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FLINTSTONE		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELMER A. CLINGERMAN						4. DATE OF DEATH Month Day Year MAY 19 1966					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 12, 1888		9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NATHAN CLINGERMAN						14. MOTHER'S MAIDEN NAME JANE BISHOP					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 157X IMMEDIATE CAUSE (a) multiple pulmonary emboli DUE TO (b) Carcinoma of the head of the Pancreas DUE TO (c) unk											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5/19/66 , to 5/19/66 , that (I) (we) last saw the deceased alive on 5/19/66 , and that death occurred at 1:12 P.M. , from causes and on the date stated above.											
22a. SIGNATURE Dr. S. G. Weisman						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/22/66			
22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN						22d. ADDRESS 59 GREENE ST. CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 22, 1966		23c. NAME OF CEMETERY OR CREMATORY Glendale Church of Brethren				23d. LOCATION (City or Town) (County) (State) Flintstone, Alleg Md.			
24. FUNERAL DIRECTOR John J. Hafer						ADDRESS 230 Balto Ave., Cumberland, Md.		25a. REC'D BY REGISTRAR MAY 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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JULY 12, 1943

WEST VIRGINIA

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JANE BISHOP

NATHAN CLINGMAN

MEMORIAL HOSPITAL

DR. J. C. WEISMAN

20 GREENE ST. CLINGMAN, MD.

MAY 23 1943

1943

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06218

CERTIFICATE OF DEATH

06214

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 15 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				d. STREET ADDRESS 114 MC CULLOUGH ST.	
3. NAME OF DECEASED (Type or print) ANNA F COLEMAN		4. DATE OF DEATH Month 5- Day 4 Year 1966		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-2-1895		9. AGE (In years last birthday) yrs. 70
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MD. ALLEGANY	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME PATRICK J. FREAL			
14. MOTHER'S MAIDEN NAME ANNA MC GREGOR		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 14-07-5720A			
16. SOCIAL SECURITY NO. 14-07-5720A		17. INFORMANT CHART			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Cachexia DUE TO (b) Metastatic Osteolytic Adenocarcinoma DUE TO (c) with pathological fracture of femur - rt					INTERVAL BETWEEN ONSET AND DEATH 1 yr 21 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Generalized Osteoporosis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) on 13 April 1966 apparently killed over in bed + anatomy changed			
20c. TIME OF INJURY Month, Day, Year Hour a.m. APR. 13 1966		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME	
20f. (City or town) CUMBERLAND		20g. (County) ALLEGANY		20h. (State) MD.	
21. I certify that (I) (this hospital) attended the deceased from 4-14 , 19 66 , to 5-3 , 19 66 , that (I) (we) last saw the deceased alive on 5-3 , 19 66 , and that death occurred at 11:45 M, from causes and on the date stated above.					
22a. SIGNATURE William R. Wolverson		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-6-66	
22c. PHYSICIAN'S NAME (Type) William R. Wolverson M.D.		22d. ADDRESS 108 Harrison St. Cumberland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5-7-1966	23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		23d. LOCATION (City or Town) (County) (State) Frostburg Md. Allegany	
24. FUNERAL DIRECTOR Joseph R. Auerst		ADDRESS Frostburg Md		25a. REC'D BY REGISTRAR MAY 9 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (6)
5M 1/65

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Edward</u> <u>Maryland</u>	
c. LENGTH OF STAY IN 1b <u>7 Months</u>		d. STREET ADDRESS <u>Sylvan Retreat</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Sylvan Retreat</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Michael</u> Last <u>Condon</u>		4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/17/1884</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Shoe Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self.</u>	
11. BIRTHPLACE (State or foreign country) <u>Edward Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Condon</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Blake</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Sylvan Retreat. Cumberland MD.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4201</u> DUE TO <u>Coronary Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work et work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		22. DATE SIGNED May 1, 1966	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		Address (Street, city, town, or county) <u>Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
<u>Burial</u>	<u>5/5/66</u>	<u>St Michaels Cem.</u>	<u>Frostburg Md</u>
24. FUNERAL DIRECTOR <u>Louis Stein Inc. Cumb. Md</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 9 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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CERTIFICATE OF DEATH

06220

06216

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b RAWLINGS Rt. # 3		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				d. STREET ADDRESS Along U.S. Rt. # 220		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NORMAN Bruce COSNER		4. DATE OF DEATH MAY 31 1966		5. AGE (In years last birthday) 67 yrs.		6. DATE OF BIRTH 5-28-99	
7. SEX MALE		8. COLOR OR RACE WHITE		9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. BIRTHPLACE (County & State, or foreign country) KITZMILLER, MARYLAND	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Carman		12. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.		13. CITIZEN OF WHAT COUNTRY? U.S.A.		14. FATHER'S NAME RANDOLPH COSNER (D)	
15. MOTHER'S MAIDEN NAME HELEN (BRAY) COSNER (D)		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		17. SOCIAL SECURITY NO.		18. INFORMANT Mrs. Nellie M. Cosner Rt. # 3 Rawlings, Md.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) acute coronary occlusion DUE TO (b) coronary occlusion DUE TO (c) arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 days 1 year 1 year		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-24 , 19 66 to 5-31 , 19 66 , that (I) (we) last saw the deceased alive on 5-31 , 19 66 , and that death occurred at 6:30 PM , from causes and on the date stated above.							
22a. SIGNATURE L. Brings		22b. ADDRESS 57 GREENE STREET CUMBERLAND, MARYLAND		22c. PHYSICIAN'S NAME (Type) DR. L. BRINGS, M.D.		22d. DATE SIGNED 6-1-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/3/66		23c. NAME OF CEMETERY OR CREMATORY Waxler Cemetery		23d. LOCATION (City or Town) (County) (State) Nr. Dansville, Allegany Md.	
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland		25a. REC'D BY REGISTRAR JUN 6 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, at any event, within 72 hours after death.

03530

0330

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH - BALTIMORE, MD.

M

06222

CERTIFICATE OF DEATH

06218

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 14 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG, MD.		d. STREET ADDRESS 39 BEALL ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) BETTY		First		Middle LOUISE		Last CROSTON		4. DATE OF DEATH Month MAY		Day 9		Year 1966							
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH JUNE 19, 1930		9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAUNDRESS				10b. KIND OF BUSINESS OR INDUSTRY MEMORIAL HOSPITAL				11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MD.				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME MARSHALL ALLEN CROSTON								14. MOTHER'S MAIDEN NAME NELLIE MAE LAYMAN											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service)				16. SOCIAL SECURITY NO. 215-26-9470				17. INFORMANT Address MEMORIAL HOSPITAL											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma pancreas DUE TO (b) with metastasis to liver DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 6:00 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 6:00 M, from causes and on the date stated above.																			
22a. SIGNATURE Earl R. Paul								22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) DR. EARL R. PAUL								22d. ADDRESS 36 GREENE ST. CUMBERLAND, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 5-13-66				23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK				23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.							
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR.,								ADDRESS FROSTBURG, MD.				25a. REC'D BY REGISTRAR MAY 18 1966				25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
06223			
CERTIFICATE OF DEATH			
06219			
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 WEEKS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL	
d. STREET ADDRESS 158 MC CULLOUGH ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ANNA VERONICA CROWE		4. DATE OF DEATH Month Day Year MAY 21 19 66	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-19-84
9. AGE (In years last birthday) 82 1/2 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) BORDEN MINES, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN (D)		14. MOTHER'S MAIDEN NAME ROSE (BARTOLOW)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NONE		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT PT'S CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral VASCULAR THROMBOSIS 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTEROSCLEROSIS DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-8 , 19 66 , to 5-21 , 19 66 , that (I) (we) last saw the deceased alive on 5-21 , 19 66 , and that death occurred at 5-21 , 19 66 , and that death occurred at 5-21 , 19 66 , from causes and on the date stated above.			
22a. SIGNATURE Dr. Michael G. Spiggle M.D.		22b. DATE SIGNED 5-23-66	
22c. PHYSICIAN'S NAME (Type) DR. SPIGGLE		22d. ADDRESS 121 N SMALLWOOD ST. CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAY 24, 1966	23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY	23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR.		25a. REC'D BY REGISTRAR MAY 26 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06225

CERTIFICATE OF DEATH

06221

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SACRED HEART HOSPITAL</u>		d. STREET ADDRESS <u>121 COLUMBIA ST.</u>	
3. NAME OF DECEASED (Type or print) <u>FRANCIS E. DEFFENBAUGH</u>		4. DATE OF DEATH <u>MAY 10 1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-10-09</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>CUMBERLAND, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD DEFFENBAUGH (D)</u>		14. MOTHER'S MAIDEN NAME <u>CECELIA (MARTZ) D()</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>70</u>	
17. INFORMANT <u>PT'S CHART</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5870</u> <u>celibrium tremens</u> DUE TO (b) <u>acute pneumonia</u> DUE TO (c) <u>acute pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-5</u> , 19 <u>66</u> , to <u>5-10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-10</u> 19 <u>66</u> , and that death occurred at <u>5</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Louis Brings</u>		22b. DATE SIGNED <u>5-10-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. L. BRINGS, MD.</u>		22d. ADDRESS <u>57 GREENE ST. CUMBERLAND, MARYLAND.</u>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/13/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter & Paul Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Cumberland Allegany MD</u>
24. FUNERAL DIRECTOR <u>Louis Stein Inc. Cumb. Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 13 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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06226

CERTIFICATE OF DEATH

06222

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAVALLE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSP.				d. STREET ADDRESS 19 GLENVIEW XX TERRACE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANCES LULA DRIVER				4. DATE OF DEATH Month Day Year 5- 16 66			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 13, 1899	
9. AGE (In years last birthday) yrs. 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOCIAL WORKER		11. BIRTHPLACE (County & State, or foreign country) Harrisonburg VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME CHARLES CLINE				14. MOTHER'S MAIDEN NAME FANNIE HELTZEL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-36-8871		17. INFORMANT Address Mr. Julian C. Driver 19 Glenview Terrace LaVale, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CLEAR CELL CARCINOMA OF RT. KIDNEY DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec , 19 65 , to 5-16 , 19 66 , that (I) (we) lost saw the deceased alive on 5-16 , 19 66 , and that death occurred at 11:30 P.M. from causes and on the date stated above.							
22a. SIGNATURE L. Michael Glick				22b. DATE SIGNED 5/17/66		22c. PHYSICIAN'S NAME (Type) L. MICHAEL GLICK	
22d. ADDRESS 126 N. SMALLWOOD				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/20/66		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland				25a. REC'D BY REGISTRAR MAY 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06227

06223

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Moscow	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA Middle FAIRGRIEVE Last FAIRGRIEVE		4. DATE OF DEATH Month 5 Day 28 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/11/1885
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Westenport, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Lee		14. MOTHER'S MAIDEN NAME Ellen Foley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Milton Todd		Address Moscow MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion 4201 DUE TO Arteriosclerosis, generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ulcerating Carcinoma, right breast		INTERVAL BETWEEN ONSET AND DEATH minutes years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 to May 28, 1966 , that (I) (we) last saw the deceased alive on May 27, 1966 , and that death occurred at 8 A.M. from the causes and on the date stated above.			
22a. SIGNATURE L.R. MILES JR. MD. M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 5-28-66	
22c. PHYSICIAN'S NAME (Type) L.R. MILES JR. MD.		22d. ADDRESS LONA CONING MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/30/1966	
23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION (City, town or county) (State) Moscow MD.	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN		ADDRESS LONA CONING, MD.	
25a. REC'D BY REGISTRAR MAY 31 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

06228

06224

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. VA. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN lb 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREENSPRING 85.3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle F. Last FIELDS				4. DATE OF DEATH Month MAY 15, Day 19 Year 66			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-26-1900 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CHARLES FIELDS				14. MOTHER'S MAIDEN NAME KANNIE KINCAID			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 236-03-5645		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS UNDERLYING: IMMEDIATE CAUSE (a) Cerebrovascular arteriosclerosis DUE TO (b) Arteriosclerosis, general, severe DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 5 days ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes arteriosclerosis Heart Disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/12, 1966 to 5/15, 1966 , that (I) (we) last saw the deceased alive on 5/15, 1966 , and that death occurred at 5:30 AM M, from causes and on the date stated above.							
22a. SIGNATURE Dr. S. G. Weisman M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/16/66	
22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN				22d. ADDRESS 59 GREENE ST.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-18-66		23c. NAME OF CEMETERY OR CREMATORY Springfield Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Springfield, Hampshire, W. Va.	
24. FUNERAL DIRECTOR Leitch & Son				25a. REC'D BY REGISTRAR MAY 20 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06229

CERTIFICATE OF DEATH

06225

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN lb 4 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 1305 MICHIGAN AVE.	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle FISHER Last FISHER		4. DATE OF DEATH Month MAY Day 3 Year 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-22-1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired B & O Employee		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 74 yrs.
11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM R. FISHER		14. MOTHER'S MAIDEN NAME XXXXX MARY V. DODD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 705-09-9962	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5705 Intestinal Obstruction associated with DUE TO (b) Cardiac decompensation, debility, with DUE TO (c) old healed tuberculosis and severe arthritis			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0082			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 1, 1966 to May 3, 1966 , that (I) (was) last saw the deceased alive on May 2, 1966 , and that death occurred at 4:50 AM from causes and on the date stated above.			
22a. SIGNATURE Carlton Brinsfield		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. CARLTON BRINSFIELD		22d. ADDRESS 401 DECATUR ST.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/6/66	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland
24. FUNERAL DIRECTOR Ruth E. Silcox Cumberland, Maryland 21502		25a. REC'D BY REGISTRAR MAY 9 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

DATE OF BIRTH

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DATE OF DEATH

CAUSE OF DEATH

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DATE OF BURIAL

PLACE OF BURIAL

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FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06230

06226

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 10 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 835 Gephart Drive	
3. NAME OF DECEASED (Type or print) First Stella Middle Irene Last Flake		4. DATE OF DEATH Month May Day 26 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 13, 1885
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 26 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ernest Smith		14. MOTHER'S MAIDEN NAME Catherine Hoffman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Martin L. Sharp		Address 835 Gephart Dr Cumberland, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) 443x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH Hours --
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Hypertension			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 26, 1966	
Address (Street, city, town, or county) Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/28/66	23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland Alleg Maryland
24. FUNERAL DIRECTOR Ruth E. Silcox		ADDRESS Cumberland Maryland 21502	
25a. REC'D BY REGISTRAR MAY 31 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

0283

U.S. DEPARTMENT OF AGRICULTURE

02830

U.S. DEPARTMENT OF AGRICULTURE

U.S. DEPARTMENT OF AGRICULTURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Item: 7 per Court Order G-759 MARYLAND STATE DEPARTMENT OF HEALTH 5/26/98 reb														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG c. LENGTH OF STAY IN 1b 1 HR. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MINERS HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY ALLEGHENY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELIZABETH d. STREET ADDRESS KESSLER HOTEL e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First LOUIS Middle FRANGOS Last FRANGOS					4. DATE OF DEATH Month MAY Day 29 Year 19 66									
5. SEX MALE					6. COLOR OR RACE WHITE					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				
8. DATE OF BIRTH NOV. 6, 1899					9. AGE (In years last birthday) 66 yrs.					IF UNDER 1 YEAR Months 66 Days 66				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESTAURANT OPERATOR					10b. KIND OF BUSINESS OR INDUSTRY OWN					11. BIRTHPLACE (State or foreign country) GREECE				
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME DIMITRIOS FRANGOS					14. MOTHER'S MAIDEN NAME GEORGIA GORGALAS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. NONE					17. INFORMANT MRS. HELEN GORGALAS, CHICAGO, ILLINOIS.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Skull Fracture; Crushed Chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (Automobile Accident) DUE TO (b) IF DUE TO (c) IF										INTERVAL BETWEEN ONSET AND DEATH 55 Minutes				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) PASSENGER IN AUTOMOBILE INVOLVED IN ACCIDENT									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 3:30 PM May 29 1966					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. #40, 3 miles East of Grantsville, Alleg. Md.				
20f. (City or town) Alleg. Md.					20g. (County) Alleg. Md.					20h. (State) Alleg. Md.				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22. DATE SIGNED May 29, 1966				
ACTUAL SIGNATURE Benedict Skitarelic					CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE THEREOF JUNE 2, 1966					23c. NAME OF CEMETERY OR CREMATORY ELMWOOD CEMETERY				
23d. LOCATION (City, town or county) RIVER GROVE, ILL.					23e. (State) ILL.									
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.					25a. REC'D BY REGISTRAR JUN 2 1966					25b. REGISTRAR'S SIGNATURE Charles Judge				

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THE UNIVERSITY OF CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06232

CERTIFICATE OF DEATH

06228

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,			c. LENGTH OF STAY IN 1b 8 HRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS 402 BEALL ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last PEARL Sarah FRICKEY				4. DATE OF DEATH Month Day Year MAY 19, 19 66			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-27-1890	
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.	
13. FATHER'S NAME GEORGE KORNS				14. MOTHER'S MAIDEN NAME ELIZABETH FRICKEY Cruthers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Far advanced coronary artery disease DUE TO 24 hrs. (c) Quick							INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-18- 19 66 , to 5-19- 19 66 that (I) (we) last saw the deceased alive on 5-18- 19 66 , and that death occurred at 6:15 AM from causes and on the date stated above.							
22a. SIGNATURE Wm. F. Williams M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-19-66	
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS				22d. ADDRESS 122 S. CENTRE ST. Cumb. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/22/66		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland				25a. REC'D BY REGISTRAR MAY 24 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

00338

CERTIFICATE OF DEATH

00338

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CUMBERLAND

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MEMORIAL HOSPITAL

102 HALL ST.

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8-27-1902

WHITE RINGS

CLIFFORD

MEMORIAL HOSPITAL, CUMBERLAND, MD.

DR. W. F. WILKINS

1952

MAY 1 1952

06238

CERTIFICATE OF DEATH

06229

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
c. LENGTH OF STAY IN lb 2 Weeks		d. STREET ADDRESS 223 DAVIDSON STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE P. GIATRAS		4. DATE OF DEATH MAY 24 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-1889
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) GREECE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Giatras		14. MOTHER'S MAIDEN NAME Annatacia Kaculeas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-32-2871	
17. INFORMANT PT'S CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis DUE TO (b) 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-12-66 , 19__, to 5-24-66 19__, that (I) (we) last saw the deceased alive on 5-24 19 66 , and that death occurred at 7 P M, from causes and on the date stated above.			
22a. SIGNATURE W. Spiggle		22b. DATE SIGNED 5-28-66	
22c. PHYSICIAN'S NAME (Type) DR. M. GLICK & SPIGGLE, M.D.		22d. ADDRESS SMALLWOOD ST. CUMBERLAND, MARYLAND.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/27/66	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Maryland	
24. FUNERAL DIRECTOR Ruth E. Silcox		25a. REC'D BY REGISTRAR MAY 31 1966	
ADDRESS Cumberland Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

06234

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06230

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 51 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 3, Valley Road		d. STREET ADDRESS Route 3, Valley Road	
3. NAME OF DECEASED (Type or print) First Kathleen Middle Grace Last Goetz		4. DATE OF DEATH Month May Day 28 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 19, 1914
9. AGE (In years last birthday) yrs. 51		10. IF UNDER 1 YEAR Months 28 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Former Nurses Aid		10b. KIND OF BUSINESS OR INDUSTRY Infirmary	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Joseph Trost		14. MOTHER'S MAIDEN NAME Effie D. Harden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT John E. Trost, Cumberland, Md.-Brother		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 353.3 IMMEDIATE CAUSE (a) ASPHYXIATION DUE TO STATUS EPILEPTICUS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) --- (c)			INTERVAL BETWEEN ONSET AND DEATH MINUTES
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED May 28, 1966		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Charles Judge Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 31, 1966	23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland, Md.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25. REC'D BY REGISTRAR JUN 2 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

06235

06231

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 MONTHS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 124 SPRING STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle T. Last GORDON				4. DATE OF DEATH Month MAY Day 22 Year 1966			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 27, 1913		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SPINNER		10b. KIND OF BUSINESS OR INDUSTRY CELANESE		11. BIRTHPLACE (County & State, or foreign country) BORDON MINES, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES H. GORDON				14. MOTHER'S MAIDEN NAME SADIE FILER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL, MEMORIAL AVE.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Cordial Failure DUE TO (b) arteriosclerotic Heart disease OUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 2 months 8 1/2 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1 Dec. , 19 65 , to 22 May , 19 66 that (I) (two) last saw the deceased alive on 21 May , 19 66 , and that death occurred at 1:10 AM from causes and on the date stated above.							
22a. SIGNATURE W. Alfred Van Ormer				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) W. A. VAN ORMER M.D.				22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 25, 1966		23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MARYLAND	
24. FUNERAL DIRECTOR HAFFER FUNERAL HOME, 60 W. MAIN ST.				25a. REC'D BY REGISTRAR MAY 31 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

06236

06232

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sylvan Retreat		d. STREET ADDRESS Detmold Street	
3. NAME OF DECEASED (Type or print) Flora		4. DATE OF DEATH Month May Day 3 Year 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 31st, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (County & State, or foreign country) Barton, MD.	
13. FATHER'S NAME George Hadley		14. MOTHER'S MAIDEN NAME Christine Fisher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT George Grindle		Address Lonaconing, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Myocardial Ch. degenerative DUE TO (b) Arteriosclerosis general & cerebral DUE TO (c) Refractured 1/2 fracture left hip CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE CONDITION GIVEN IN PART I (a) 17th Street property		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 5, 1964 , to May 3, 1966 that (I) (we) lost the deceased alive on May 3, 1966 , and that death occurred at 10 AM , from causes and on the date stated above.			
22a. SIGNATURE L. B. Mathews, M.D.		22b. DATE SIGNED MAY 5 1966	
22c. PHYSICIAN'S NAME (Type) L. B. Mathews, M.D.		22d. ADDRESS 49 Greene Street, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/6/1966	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Moscow, MD.
24. FUNERAL DIRECTOR George Eichhorn		25a. REC'D BY REGISTRAR MAY 5 1966	
ADDRESS Lonaconing, MD.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DEPARTMENT OF HEALTH

88330

2000 Street

George, 1888

George, 1888

George, 1888

George, 1888
(1888)

George, 1888

George, 1888

George, 1888
MAY 1888

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item 8 Film G377 6/7/66 mh											
06237						06233					
1. PLACE OF DEATH a. COUNTY Maryland b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN lb 74 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 415 Bedford Street						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland Md. d. STREET ADDRESS 415 Bedford St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Rose E. Harbaugh						4. DATE OF DEATH May 26 19 66					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1891 August 30, 1891		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book Store Owner				10b. KIND OF BUSINESS OR INDUSTRY Books				11. BIRTHPLACE (County & State, or foreign country) Cumberland Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Harbaugh						14. MOTHER'S MAIDEN NAME Martha Hickey					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. —					
17. INFORMANT John W. Harbaugh						Address 415 Bedford St.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertensive Heart Disease 34 yrs. (c) Malignant hypertension 34 yrs.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) None		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 9, 19 62 to May 26, 19 66 , that (I) (we) last saw the deceased alive on May 26, 19 66 , and that death occurred at 5:05 PM from the causes and on the date stated above.											
22a. SIGNATURE James P. Hallinan M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) James P. Hallinan M. D.						22b. ADDRESS 140 Bedford St., Cumberland, Md.		22b. DATE SIGNED 5-27-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 5/28/66		23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem.		23d. LOCATION (City, town or county) Cumberland		(State) Md			
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.						ADDRESS Cumberland Md		25a. REC'D BY REGISTRAR MAY 31 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

CERTIFICATE OF DEATH

06238

06234

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle Everett Last HEFFER		4. DATE OF DEATH Month MAY Day 24 Year 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 4, 1895
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter		10b. KIND OF BUSINESS OR INDUSTRY Textile	
11. BIRTHPLACE (County & State, or foreign country) KANSAS JUNCTION CITY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN HEFFER		14. MOTHER'S MAIDEN NAME EUGENIA OLIVER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-24-8640	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 241X Thrombia DUE TO (b) Myocarditis DUE TO (c) Cisterna		INTERVAL BETWEEN ONSET AND DEATH 5 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 7, 1938 to May 27, 1966 that (I) (we) last saw the deceased alive on May 24, 1966 and that death occurred at 8:00 AM from causes and on the date stated above.			
22a. SIGNATURE Clay E. Durrett M.D.		22b. DATE SIGNED 5/25/66	
22c. PHYSICIAN'S NAME (Type) CLAY E. DURRETT		22d. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 26, 1966	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR MAY 27 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

2250

2252

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
06239					06235					
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland			01-1		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 512 Shriver Avenue					d. STREET ADDRESS 512 Shriver Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Etta Middle Clara Last Heinrich					4. DATE OF DEATH Month May Day 28 Year 1966					
5. SEX Female		6. COLOR OF RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 5, 1878		9. AGE (In years last birthday) 87 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Allegany, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Horace R. Twigg					14. MOTHER'S MAIDEN NAME Laurena Middleton					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 220-46-4537		17. INFORMANT W. Lester Heinrich,			Address LaVale, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic glomerulonephritis DUE TO (c) Arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH Weeks --- ---		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from January, 1966 to May 28, 1966 , that (I) (we) last saw the deceased alive on May 27, 1966 , and that death occurred at 10 p.m. from the causes and on the date stated above.										
22a. SIGNATURE Benedict Skitarelic					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 30, 1966			
22c. PHYSICIAN'S NAME (Type) DR. BENEDICT SKITARELIC					22d. ADDRESS Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 1, 1966		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park			23d. LOCATION (City, town or county) (State) Near Cumberland, Maryland			
24. FUNERAL DIRECTOR John J. Mafer, Jr.					ADDRESS 230 Baltimore Avenue		25a. REC'D BY REGISTRAR JUN 3 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	
					Cumberland, Md.					

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STATE OF TEXAS

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Chesapeake

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312 River Avenue

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July 2, 1975

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Lawrence Robinson

Lawrence Robinson

Allegany, Maryland

Allegany, Maryland

330-4-457

Allegany

Allegany

Allegany

Allegany, Maryland

Allegany, Maryland

January 27, 1975

27

27

July 20, 1975

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Allegany

330-4-457

July

Allegany, Maryland

Allegany, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06240

CERTIFICATE OF DEATH

06236

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 513 PATTERSON AVE.	
3. NAME OF DECEASED (Type or print) First Middle Last OTHALIA Alma HENDLEY		4. DATE OF DEATH Month Day Year MAY 24 19 66	
5. SEX WHITE	6. COLOR OR RACE FEMALE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH MARCH 22, 18 94
9. AGE (In years last birthday) 72		10. IF UNDER 1 YEAR Months Days Hours Min. 19 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical nurse		10b. KIND OF BUSINESS OR INDUSTRY County Infirmary	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND Eckhart		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM MURRAY		14. MOTHER'S MAIDEN NAME CLARA SCHELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No,		16. SOCIAL SECURITY NO. 218-32-8526	
17. INFORMANT Mrs. Robert W. Ritter		Address 513 Patterson Ave. Cumb. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Subarachnoid hemorrhage DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/22 7:45 PM to 5/24, 19 66 that (I) (we) last saw the deceased alive on 5/24 19 66 , and that death occurred at 7:45 PM , from causes and on the date stated above.			
22a. SIGNATURE William P. James		22b. DATE SIGNED 5/26/66	
22c. PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES		22d. ADDRESS 441 N. CENTRE ST. CUMB.MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/27/66	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR H. Wayne George		ADDRESS Cumberland, Md.	
25a. REC'D BY REGISTRAR MAY 31 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

65330

CERTIFICATE OF DEATH

65330

DATE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

CAUSE OF DEATH

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MAY 1 1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

Item 9 Film G377 6/7/66 mh

06241

CERTIFICATE OF DEATH

06237

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 4 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		d. STREET ADDRESS 408 Walnut St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Fannie L. Higgins		4. DATE OF DEATH Month May Day 29 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-11-79
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 10 Days 18 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Orleans ME		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Higgins		14. MOTHER'S MAIDEN NAME Elizabeth Hudson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Pt. chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — (c) —		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/26 , 19 66 , to 7/29 , 19 66 , that (I) (we) last saw the deceased alive on 7/29 , 19 66 , and that death occurred at 1:30 P.M. from causes on and the date stated above.			
22a. SIGNATURE Leo H. Ley, Jr.		22b. DATE SIGNED 5/31/66	
22c. PHYSICIAN'S NAME (Type) Leo H. Ley M.D.		22d. ADDRESS 456 N. Centre St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/1/66	
23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cema		23d. LOCATION (City or Town) (County) (State) Cumberland MD	
24. FUNERAL DIRECTOR Louis Stein Inc, Cumb. MD		25a. REC'D BY REGISTRAR JUN 3 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

10330

REPORT OF OFFICER

10330

On this day, I, the undersigned, being duly sworn, depose and say that the following is a true and correct copy of the report of the officer on duty at the time of the occurrence of the above described event.

Subscribed and sworn to before me this day of _____, 19__.

Notary Public for the State of Massachusetts

My commission expires on the _____ day of _____, 19__.

Witness my hand and the seal of my office this day of _____, 19__.

Notary Public for the State of Massachusetts

My commission expires on the _____ day of _____, 19__.

Witness my hand and the seal of my office this day of _____, 19__.

Notary Public for the State of Massachusetts

My commission expires on the _____ day of _____, 19__.

Witness my hand and the seal of my office this day of _____, 19__.

Notary Public for the State of Massachusetts

My commission expires on the _____ day of _____, 19__.

Witness my hand and the seal of my office this day of _____, 19__.

Notary Public for the State of Massachusetts

My commission expires on the _____ day of _____, 19__.

Witness my hand and the seal of my office this day of _____, 19__.

Notary Public for the State of Massachusetts

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

(M)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06242

06238

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN lb 8 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 17 RIDGEWAY TERRACE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First NORA Middle G Last HINKLE		4. DATE OF DEATH Month MAY Day 28 Year 19 66			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH SEPT. 7, 1872		9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR Months 8 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN RICE			
14. MOTHER'S MAIDEN NAME JULIA NEWELL		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 219-46-2497		17. INFORMATION MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Cardiac Failure 4221 DUE TO (b) Pneumonia, atypical, L.L.L., C.H. DUE TO (c) A.S. Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 8 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Men. arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 20 May , 19 66 , to 28 May , 19 66 , that (I) (we) last saw the deceased alive on 28 May , 19 66 , and that death occurred 1:05 PM , from causes and on the date stated above.					
22a. SIGNATURE W. Alfred Van Ormer		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 29 May 66	
22c. PHYSICIAN'S NAME (Type) WILLIAM A. VAN ORMER		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/31/66		23c. NAME OF CEMETERY OR CREMATORY Mt Pleasant Cemetery	
23d. LOCATION (City or Town) (County) (State) Cumberland Alleg Maryland					
24. FUNERAL DIRECTOR Ruth E. Silcox Cumberland, Maryland 21502		ADDRESS		25a. REC'D BY REGISTRAR JUN 1 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge					

101

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ALLEGANY

WYOMING

ALLEGANY

CONGOLAND

CONGOLAND

17 RINGWAY TERRACE

MEMORIAL HOSPITAL

HORA

WYOMING

FEMALE WHITE

1875-1875

U.S.A.

CONGOLAND, WY.

JOHN RICE

WYOMING

MEMORIAL HOSPITAL, CONGOLAND, WY.

WYOMING A. VAN ORMER

133 S. CENTRE ST., CONGOLAND, WY.

WYOMING 1885

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Alleg any</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland Md</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Rechtler Nursing Home</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Alleg any</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland Md.</i> d. STREET ADDRESS <i>306 Schley Street</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Roy</i> Middle <i>A.</i> Last <i>Hirsch</i>		4. DATE OF DEATH Month <i>May</i> Day <i>23</i> Year <i>1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/14/73</i>
9. AGE (In years, last birthday) <i>92</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Pittsburg Penna</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Adolph Abrams</i>		14. MOTHER'S MAIDEN NAME <i>Charlotina Fink</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mr. Sumner Hirsch</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> 4500 DUE TO <i>Cordis Perforation</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>myocardial infarction</i> DUE TO <i>—</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>May 15</i> , 19 <i>66</i> , to <i>May 23</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>May 15</i> , 19 <i>66</i> , and that death occurred at <i>11</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>R. H. Richter</i>		22b. DATE SIGNED <i>May 23 1966</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/24/66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>East View Cem.</i>		23d. LOCATION (City, town or county) (State) <i>Cumberland Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein Inc.</i>		25a. REC'D BY REGISTRAR <i>MAY 25 1966</i>	
ADDRESS <i>Cumb. Md</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1880

1880

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Mr. S. M. H. H. H." and "1880" are visible.]

[Faint handwritten text at the bottom of the page, including "1880" and "May 2 1880".]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH					
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
06244 CERTIFICATE OF DEATH 06240					
1. PLACE OF DEATH a. COUNTY ALLEGANY COUNTY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN TB 1 Day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 119 Grand Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First WALTER Middle S. Last HOLTZMAN			4. DATE OF DEATH Month MAY Day 1 Year 19 66		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9-18-1895		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 1 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Paint Contractor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE W HOLTZMAN		14. MOTHER'S MAIDEN NAME MINNIE NEWCOMB	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-07-6318		17. INFORMANT Mrs. Pearl Holtzman Address 119 Grand Avenue Cumberland, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Art. Felt Cope DUE TO (b) Arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 40 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland, Md	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 4/30/66 , 19 19 , to 5/1/66 , 19 19 , that (I) (we) last saw the deceased alive on 5/1/66 , 19 19 , and that death occurred at 3:30 PM , from causes and on the date stated above.					
22a. SIGNATURE [Signature]		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/3/66	
22c. PHYSICIAN'S NAME (Type) DR. CLAY E BURRETT		22d. ADDRESS 236 VIRGINIA AVE. CUMBERLAND, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/4/66		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	
23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland					
24. FUNERAL DIRECTOR Ruth E. Silcox		ADDRESS Cumberland Maryland 21502		25a. REC'D BY REGISTRAR MAY 6 1966	
25b. REGISTRAR'S SIGNATURE [Signature]					

06840

CERTIFICATE OF DEATH

06840

ALLEGANY COUNTY

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CURSE 1 AND

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MEMORIAL HOSPITAL

MAY 22

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MALE WHITE

0-18-1904

GEORGE W. HOLZMAN

NEWCOMB

1904

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
GM 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 49 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Memorial Hospital		d. STREET ADDRESS 617 Elwood St.	
3. NAME OF DECEASED (Type or print) First Middle Last Thelma Margaret Hymes		4. DATE OF DEATH Month Day Year May 21 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1916
9. AGE (In years lost birthday) yrs. 49		10. IF UNDER 1 YEAR Months Days Hours Min. 21 19 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Alfred Shoemaker		14. MOTHER'S MAIDEN NAME Hazel Ambrose	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. Mr. W. Monroe Hymes, Cumberland, Md.	
17. INFORMANT Mr. W. Monroe Hymes, Cumberland, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary Sclerosis (c) Coronary Sclerosis		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, MD.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> May 21, 1966	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county) Rt. 9 Cumberland		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 24, 1966	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR MAY 24 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

1 (M)

06246

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06246

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b D. O. A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS 99 BOWERY STREET	
3. NAME OF DECEASED (Type or print) First Middle Last NELLIE A. JAMES		4. DATE OF DEATH Month Day Year MAY 13, 19 66	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 1, 1940
9. AGE (In years lost birthday) 25 yrs.		10. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ELLSWORTH GRAY		14. MOTHER'S MAIDEN NAME KATIE KILROY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT THOS. J. JAMES, 99 BOWERY ST., FROSTBURG, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATO RENAL SHOCK 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE FATTY LIVER DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH HOURS DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PULMONARY CONGESTION AND EDEMA		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED May 13, 1966		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 16, 1966	
23c. NAME OF CEMETERY OR CREMATORY LAUREL HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) BARTON, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		25a. REC'D BY REGISTRAR MAY 17 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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VS. A15ME
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
5. SEX		6. COLOR OR RACE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	
11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. NAME OF CEMETERY OR CREMATORY	
23. FUNERAL DIRECTOR		24. REC'D BY REGISTRAR	
25. DATE THEREOF		26. REGISTRAR'S SIGNATURE	
27. NAME OF CEMETERY OR CREMATORY		28. LOCATION (City, town, or country)	
29. DATE OF DEATH		30. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
31. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		32. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
33. SEX		34. COLOR OR RACE	
35. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		36. DATE OF BIRTH	
37. AGE (In years last birthday)		38. IF UNDER 1 YEAR	
39. IF UNDER 24 HRS.		40. CITIZEN OF WHAT COUNTRY	
41. FATHER'S NAME		42. MOTHER'S MAIDEN NAME	
43. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown)		44. SOCIAL SECURITY NO.	
45. INFORMANT		46. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
47. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		48. DATE OF DEATH	
49. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		50. NAME OF CEMETERY OR CREMATORY	
51. DATE THEREOF		52. REGISTRAR'S SIGNATURE	
53. NAME OF CEMETERY OR CREMATORY		54. LOCATION (City, town, or country)	
55. DATE OF DEATH		56. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
57. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		58. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
59. SEX		60. COLOR OR RACE	
61. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		62. DATE OF BIRTH	
63. AGE (In years last birthday)		64. IF UNDER 1 YEAR	
65. IF UNDER 24 HRS.		66. CITIZEN OF WHAT COUNTRY	
67. FATHER'S NAME		68. MOTHER'S MAIDEN NAME	
69. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown)		70. SOCIAL SECURITY NO.	
71. INFORMANT		72. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
73. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		74. DATE OF DEATH	
75. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		76. NAME OF CEMETERY OR CREMATORY	
77. DATE THEREOF		78. REGISTRAR'S SIGNATURE	
79. NAME OF CEMETERY OR CREMATORY		80. LOCATION (City, town, or country)	
81. DATE OF DEATH		82. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
83. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		84. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
85. SEX		86. COLOR OR RACE	
87. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		88. DATE OF BIRTH	
89. AGE (In years last birthday)		90. IF UNDER 1 YEAR	
91. IF UNDER 24 HRS.		92. CITIZEN OF WHAT COUNTRY	
93. FATHER'S NAME		94. MOTHER'S MAIDEN NAME	
95. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown)		96. SOCIAL SECURITY NO.	
97. INFORMANT		98. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
99. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		100. DATE OF DEATH	
101. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		102. NAME OF CEMETERY OR CREMATORY	
103. DATE THEREOF		104. REGISTRAR'S SIGNATURE	
105. NAME OF CEMETERY OR CREMATORY		106. LOCATION (City, town, or country)	
107. DATE OF DEATH		108. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
109. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		110. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
111. SEX		112. COLOR OR RACE	
113. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		114. DATE OF BIRTH	
115. AGE (In years last birthday)		116. IF UNDER 1 YEAR	
117. IF UNDER 24 HRS.		118. CITIZEN OF WHAT COUNTRY	
119. FATHER'S NAME		120. MOTHER'S MAIDEN NAME	
121. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown)		122. SOCIAL SECURITY NO.	
123. INFORMANT		124. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
125. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		126. DATE OF DEATH	
127. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		128. NAME OF CEMETERY OR CREMATORY	
129. DATE THEREOF		130. REGISTRAR'S SIGNATURE	
131. NAME OF CEMETERY OR CREMATORY		132. LOCATION (City, town, or country)	
133. DATE OF DEATH		134. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
135. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		136. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
137. SEX		138. COLOR OR RACE	
139. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		140. DATE OF BIRTH	
141. AGE (In years last birthday)		142. IF UNDER 1 YEAR	
143. IF UNDER 24 HRS.		144. CITIZEN OF WHAT COUNTRY	
145. FATHER'S NAME		146. MOTHER'S MAIDEN NAME	
147. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown)		148. SOCIAL SECURITY NO.	
149. INFORMANT		150. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
151. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		152. DATE OF DEATH	
153. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural			

1952

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Allegany

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06248

06244

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 5 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		d. STREET ADDRESS 194 WEST MAIN STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SUSAN Middle RUTH Last JONES				4. DATE OF DEATH Month MAY Day 22 Year 1966			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 27, 1893	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73		IF UNDER 24 HRS. Hours 73 Min. 73			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) R.F.D. MEYERSDALE, PA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME LEWIS KNEPP				14. MOTHER'S MAIDEN NAME AGNES SUDER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. SARA STEINA, 194 W. MAIN ST.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiac Disease & Failed DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. obstructive portal system DUE TO obstructive portal system PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 2 weeks years 1 week			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1955 to May 22 1966 that (I) (we) last saw the deceased alive on May 22 1966 and that death occurred at 12A M, from the causes and on the date stated above.							
22a. SIGNATURE John B. Davis M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/24/66	
22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M.D.				22d. ADDRESS 2 BROADWAY, FROSTBURG, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 25, 1966		23c. NAME OF CEMETERY OR CREMATORY WHITE OAK CEMETERY		23d. LOCATION (City, town or county) (State) MEYERSDALE, PA.	
24. FUNERAL DIRECTOR'S SIGNATURE HAER FUNERAL HOME, 60 W. MAIN STREET				25a. REC'D BY REGISTRAR MAY 31 1966		25b. REGISTRAR'S SIGNATURE John B. Davis	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ALLEGANY

FROSTBURG

MINERS HOSPITAL

SUSAN

WHITE

HOUSEWIFE

LEWIS KNEPP

NO

NONE

5 DAYS

HUGH

JONES

JAN. 27, 1893

R.F.D. WEYERSDALE, PA. U.S.A.

AGNES SUDER

MRS. SARA STEINA, 14 W. MAIN ST.

FROSTBURG, MD.

14 WEST MAIN STREET

FROSTBURG

MARYLAND

ALLGANY

BURIAL

MAY 25, 1966 WHITE OAK CEMETERY

FROSTBURG, MD.

HAFER FUNERAL HOME, 60 W. MAIN STREET

MAY 31 1966

WEYERSDALE

2 BROADWAY, FROSTBURG, MD.

JOHN B. DAVIS, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06245

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>699 Gephart Dr.</u>				d. STREET ADDRESS <u>699 Gephart Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Francis</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>1966</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/11/1895</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>	IF UNDER 24 HRS. Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Brooklyn, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Richard Jones</u>				14. MOTHER'S MAIDEN NAME <u>Mary Donovan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-05-8944</u>		17. INFORMANT <u>Mrs. Mary Webel</u> Address <u>699 Gephart Dr. Cumb., Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>5020</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cor Pulmonale</u> DUE TO (c) <u>Chronic Bronchitis and Pulmonary Emphysema.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 years</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1964</u> , 19 <u>64</u> , to <u>May 14th</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>May 14th</u> , 19 <u>66</u> , and that death occurred at <u>4:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>414 N. Mechanic St., Cumberland, Md.</u> DATE SIGNED <u>5-16-66</u> ACTUAL SIGNATURE <u>Wyand F. Doerner, Jr.</u> M.D. PHYSICIAN'S NAME (Type) <u>Wyand F. Doerner, Jr., M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/17/66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter & Paul Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u> ADDRESS <u>Cumberland, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 23 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06250

CERTIFICATE OF DEATH

06246

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 20 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		01-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 202 VA. AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWARD Middle (Thomas) Last T. JOYCE		4. DATE OF DEATH Month MAY Day 23 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-14-07
9. AGE (In years birthday yrs.) 59		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10b. KIND OF BUSINESS OR INDUSTRY Club	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS E. JOYCE		14. MOTHER'S MAIDEN NAME ELLEN ROWAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WAR II		16. SOCIAL SECURITY NO.	
17. INFORMANT PATIENT'S CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute mesenteric thrombosis 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 3 , 1966, to May 23 , 1966, that (I) (we) last saw the deceased alive on May 22 , 1966, and that death occurred at 3:15 PM from causes and on the date stated above.			
22a. SIGNATURE Dr. Earl R. Paul		22b. DATE SIGNED 5-26-66	
22c. PHYSICIAN'S NAME (Type) Dr. Earl R. Paul		22d. ADDRESS 36 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 26, 1966	
23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR MAY 31 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

1930

REPORT OF DEATH

67230

That mother
is the best of friends

Paula M. [Signature]

3307

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06251

CERTIFICATE OF DEATH

Item 7 Film G377 6/10/66 mh

06247

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE W. Va. b. COUNTY Tucker			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsons			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kyle Nursing Home				d. STREET ADDRESS 85 3			
3. NAME OF DECEASED (Type or print) First George Middle Judy Last Judy				4. DATE OF DEATH Month May Day 8th Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 20, 1907	9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months 3 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumberman Woods		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Randolph Co., W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Daniel Judy				14. MOTHER'S MAIDEN NAME Laura Bell Aimes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 236-14-6212		17. INFORMANT Records At Kyle Nursing Home, Lonaconing, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACVD DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 4, 1966 to May 8, 1966 that (I) (we) last saw the deceased alive on May 4, 1966 , and that death occurred at 5 M , from the causes and on the date stated above.							
22a. SIGNATURE L. R. Miles, Jr., M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-9-66	
22c. PHYSICIAN'S NAME (Type) L. R. MILES, JR., M.D.				22d. ADDRESS LONA CONING MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Removal Burial		5-10-1966		Leadmine Cemetery		Leadmine, Tucker Co., W. Va.	
24 FUNERAL DIRECTOR'S SIGNATURE Allen M. Rotruck, Keyser, WV				25a. REC'D BY REGISTRAR JUN 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06252

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06248

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 60 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital			d. STREET ADDRESS 22 Potomac Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Jacob Middle Elliott Last Keller			4. DATE OF DEATH Month May Day 28 Year 1966		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1896		9. AGE (In years last birthday) yrs. 69
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Chambersburg, Pa.	
13. FATHER'S NAME Martin L. Keller			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO.		
17. INFORMANT Mr. Harold E. Keller, Hagerstown, Md.-Son			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 9010 IMMEDIATE CAUSE (a) Contusions of Brain, Subdural Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Skull Fracture DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mesenteric Thrombosis, terminal					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from Ladder at Home			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:20 p.m. May 24 19 66		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cumberland, Alleg. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED May 28, 1966	
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Rt. 9, Cumberland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 31, 1966	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Md.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.			25a. REC'D BY REGISTRAR JUN 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06253

CERTIFICATE OF DEATH

06249

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1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN b1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>419 Washington St.</u>			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> d. STREET ADDRESS <u>419 Washington St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Mary Cecelia Kelly</u>		4. DATE OF DEATH <u>May 10 1966</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Aug. 21, 1903</u> 9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law Office</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Westernport, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John J. Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Footen</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give year or dates of service)	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Margaret Kelly</u> Address <u>Cumberland, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of left breast with metastases to the left upper lobe, and the brain</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>170X</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>May</u>	
20f. (City or town) <u>May</u> (County) <u>—</u> (State) <u>—</u>		21. I certify that (I) (this hospital) attended the deceased from <u>April 30, 1966</u> to <u>5/10/66</u> , that (I) (we) last saw the deceased alive on <u>April 30, 1966</u> , and that death occurred at <u>4:00</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>S. G. WEISMAN</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/11/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>S. G. WEISMAN MD</u>		22d. ADDRESS <u>59 Greene St Cumberland, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 13, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter & Paul Cemetery</u> (State) <u>Md.</u>	
23d. LOCATION (City, town or county) <u>Cumberland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u> ADDRESS <u>Cumberland, Md.</u>			
25a. REC'D BY REGISTRAR <u>MAY 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06254

CERTIFICATE OF DEATH

06250

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 9 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		d. STREET ADDRESS 362 Williams Road	
3. NAME OF DECEASED (Type or print) Francis De Sales(D.) King		4. DATE OF DEATH Month May Day 30 Year 19 66	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		10b. KIND OF BUSINESS OR INDUSTRY RR Railroad	
11. BIRTHPLACE (County & State, or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stephen F. King		14. MOTHER'S MAIDEN NAME Catherine ? McCamley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 705-09-9520	
17. INFORMANT Pt. Chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Myocardial infarction DUE TO (c) Arteriosclerotic Heart Disease DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 3 weeks unk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/22 , 19 66 , to 5/30 , 19 66 , that (I) (we) last saw the deceased alive on 5/29 , 19 66 , and that death occurred at 12:00 M, from causes and on the date stated above.			
22a. SIGNATURE S. Weisman		22b. DATE SIGNED 5/31/66	
22c. PHYSICIAN'S NAME (Type) S. Weisman M.D.		22d. ADDRESS 9 Green St Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 2, 1966	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR JUN 6 1966	
		25b. REGISTRAR'S SIGNATURE J Charles Judge	

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GENERAL INFORMATION		SPECIFIC INFORMATION	
NAME	ADDRESS	DATE	TIME
John Doe	123 Main St, New York, NY	10/10/2023	10:00 AM
Jane Smith	456 Elm St, Los Angeles, CA	10/11/2023	09:30 AM
Bob Johnson	789 Oak St, Chicago, IL	10/12/2023	11:00 AM
Alice Brown	101 Pine St, San Francisco, CA	10/13/2023	08:45 AM
Charlie Davis	202 Cedar St, Houston, TX	10/14/2023	12:00 PM
Diana Evans	303 Birch St, Phoenix, AZ	10/15/2023	07:30 AM
Frank Green	404 Spruce St, Portland, OR	10/16/2023	06:00 PM
Grace Hall	505 Willow St, Seattle, WA	10/17/2023	05:00 PM
Henry King	606 Ash St, Denver, CO	10/18/2023	04:00 PM
Ivy Lee	707 Hickory St, Dallas, TX	10/19/2023	03:00 PM
Jack Miller	808 Sycamore St, San Antonio, TX	10/20/2023	02:00 PM
Karen Wilson	909 Magnolia St, Austin, TX	10/21/2023	01:00 PM
Leo White	1010 Dogwood St, Fort Worth, TX	10/22/2023	12:00 PM
Mia Black	1111 Redwood St, El Paso, TX	10/23/2023	11:00 AM
Noah Gray	1212 Cypress St, El Paso, TX	10/24/2023	10:00 AM
Olivia Blue	1313 Juniper St, El Paso, TX	10/25/2023	09:00 AM
Peter Red	1414 Fir St, El Paso, TX	10/26/2023	08:00 AM
Quinn Yellow	1515 Palm St, El Paso, TX	10/27/2023	07:00 AM
Rachel Purple	1616 Cedar St, El Paso, TX	10/28/2023	06:00 AM
Sam Green	1717 Birch St, El Paso, TX	10/29/2023	05:00 AM
Tina Brown	1818 Spruce St, El Paso, TX	10/30/2023	04:00 AM
Uma White	1919 Willow St, El Paso, TX	10/31/2023	03:00 AM
Victor Black	2020 Ash St, El Paso, TX	11/01/2023	02:00 AM
Wendy Gray	2121 Hickory St, El Paso, TX	11/02/2023	01:00 AM
Xavier Blue	2222 Sycamore St, El Paso, TX	11/03/2023	12:00 AM
Yara Red	2323 Magnolia St, El Paso, TX	11/04/2023	11:00 PM
Zoe Yellow	2424 Dogwood St, El Paso, TX	11/05/2023	10:00 PM
Adam Purple	2525 Redwood St, El Paso, TX	11/06/2023	09:00 PM
Eve Green	2626 Cypress St, El Paso, TX	11/07/2023	08:00 PM
Frank Brown	2727 Juniper St, El Paso, TX	11/08/2023	07:00 PM
Grace White	2828 Fir St, El Paso, TX	11/09/2023	06:00 PM
Henry Black	2929 Palm St, El Paso, TX	11/10/2023	05:00 PM
Ivy Gray	3030 Cedar St, El Paso, TX	11/11/2023	04:00 PM
Jack Blue	3131 Birch St, El Paso, TX	11/12/2023	03:00 PM
Karen Red	3232 Spruce St, El Paso, TX	11/13/2023	02:00 PM
Leo Yellow	3333 Willow St, El Paso, TX	11/14/2023	01:00 PM
Mia Purple	3434 Ash St, El Paso, TX	11/15/2023	12:00 PM
Noah Green	3535 Hickory St, El Paso, TX	11/16/2023	11:00 AM
Olivia Brown	3636 Sycamore St, El Paso, TX	11/17/2023	10:00 AM
Peter White	3737 Magnolia St, El Paso, TX	11/18/2023	09:00 AM
Quinn Black	3838 Dogwood St, El Paso, TX	11/19/2023	08:00 AM
Rachel Gray	3939 Redwood St, El Paso, TX	11/20/2023	07:00 AM
Sam Blue	4040 Cypress St, El Paso, TX	11/21/2023	06:00 AM
Tina Red	4141 Juniper St, El Paso, TX	11/22/2023	05:00 AM
Uma Yellow	4242 Fir St, El Paso, TX	11/23/2023	04:00 AM
Victor Purple	4343 Palm St, El Paso, TX	11/24/2023	03:00 AM
Wendy Green	4444 Cedar St, El Paso, TX	11/25/2023	02:00 AM
Xavier Brown	4545 Birch St, El Paso, TX	11/26/2023	01:00 AM
Yara White	4646 Spruce St, El Paso, TX	11/27/2023	12:00 AM
Zoe Black	4747 Willow St, El Paso, TX	11/28/2023	11:00 PM
Adam Gray	4848 Ash St, El Paso, TX	11/29/2023	10:00 PM
Eve Blue	4949 Hickory St, El Paso, TX	11/30/2023	09:00 PM
Frank Red	5050 Sycamore St, El Paso, TX	12/01/2023	08:00 PM
Grace Yellow	5151 Magnolia St, El Paso, TX	12/02/2023	07:00 PM
Henry Purple	5252 Dogwood St, El Paso, TX	12/03/2023	06:00 PM
Ivy Green	5353 Redwood St, El Paso, TX	12/04/2023	05:00 PM
Jack Brown	5454 Cypress St, El Paso, TX	12/05/2023	04:00 PM
Karen White	5555 Juniper St, El Paso, TX	12/06/2023	03:00 PM
Leo Black	5656 Fir St, El Paso, TX	12/07/2023	02:00 PM
Mia Gray	5757 Palm St, El Paso, TX	12/08/2023	01:00 PM
Noah Blue	5858 Cedar St, El Paso, TX	12/09/2023	12:00 PM
Olivia Red	5959 Birch St, El Paso, TX	12/10/2023	11:00 AM
Peter Yellow	6060 Spruce St, El Paso, TX	12/11/2023	10:00 AM
Quinn Purple	6161 Willow St, El Paso, TX	12/12/2023	09:00 AM
Rachel Green	6262 Ash St, El Paso, TX	12/13/2023	08:00 AM
Sam Brown	6363 Hickory St, El Paso, TX	12/14/2023	07:00 AM
Tina White	6464 Sycamore St, El Paso, TX	12/15/2023	06:00 AM
Uma Black	6565 Magnolia St, El Paso, TX	12/16/2023	05:00 AM
Victor Gray	6666 Dogwood St, El Paso, TX	12/17/2023	04:00 AM
Wendy Blue	6767 Redwood St, El Paso, TX	12/18/2023	03:00 AM
Xavier Red	6868 Cypress St, El Paso, TX	12/19/2023	02:00 AM
Yara Yellow	6969 Juniper St, El Paso, TX	12/20/2023	01:00 AM
Zoe Purple	7070 Fir St, El Paso, TX	12/21/2023	12:00 AM
Adam Green	7171 Palm St, El Paso, TX	12/22/2023	11:00 PM
Eve Brown	7272 Cedar St, El Paso, TX	12/23/2023	10:00 PM
Frank White	7373 Birch St, El Paso, TX	12/24/2023	09:00 PM
Grace Black	7474 Spruce St, El Paso, TX	12/25/2023	08:00 PM
Henry Gray	7575 Willow St, El Paso, TX	12/26/2023	07:00 PM
Ivy Blue	7676 Ash St, El Paso, TX	12/27/2023	06:00 PM
Jack Red	7777 Hickory St, El Paso, TX	12/28/2023	05:00 PM
Karen Yellow	7878 Sycamore St, El Paso, TX	12/29/2023	04:00 PM
Leo Purple	7979 Magnolia St, El Paso, TX	12/30/2023	03:00 PM
Mia Green	8080 Dogwood St, El Paso, TX	12/31/2023	02:00 PM
Noah Brown	8181 Redwood St, El Paso, TX	01/01/2024	01:00 PM
Olivia White	8282 Cypress St, El Paso, TX	01/02/2024	12:00 PM
Peter Black	8383 Juniper St, El Paso, TX	01/03/2024	11:00 AM
Quinn Gray	8484 Fir St, El Paso, TX	01/04/2024	10:00 AM
Rachel Blue	8585 Palm St, El Paso, TX	01/05/2024	09:00 AM
Sam Red	8686 Cedar St, El Paso, TX	01/06/2024	08:00 AM
Tina Yellow	8787 Birch St, El Paso, TX	01/07/2024	07:00 AM
Uma Purple	8888 Spruce St, El Paso, TX	01/08/2024	06:00 AM
Victor Green	8989 Willow St, El Paso, TX	01/09/2024	05:00 AM
Wendy Brown	9090 Ash St, El Paso, TX	01/10/2024	04:00 AM
Xavier White	9191 Hickory St, El Paso, TX	01/11/2024	03:00 AM
Yara Black	9292 Sycamore St, El Paso, TX	01/12/2024	02:00 AM
Zoe Gray	9393 Magnolia St, El Paso, TX	01/13/2024	01:00 AM
Adam Blue	9494 Dogwood St, El Paso, TX	01/14/2024	12:00 AM
Eve Red	9595 Redwood St, El Paso, TX	01/15/2024	11:00 PM
Frank Yellow	9696 Cypress St, El Paso, TX	01/16/2024	10:00 PM
Grace Purple	9797 Juniper St, El Paso, TX	01/17/2024	09:00 PM
Henry Green	9898 Fir St, El Paso, TX	01/18/2024	08:00 PM
Ivy Brown	9999 Palm St, El Paso, TX	01/19/2024	07:00 PM
Jack White	0000 Cedar St, El Paso, TX	01/20/2024	06:00 PM

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1D Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 604 Winifred Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 604 Winifred Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Firat Middle Last Rosa Belle King		4. DATE OF DEATH May 15 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 29, 1890
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR: Months 15 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph Ellsworth		14. MOTHER'S MAIDEN NAME Dema Robinette	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-28-7558	
17. INFORMANT Mrs. Aileen Hendra, Park, Cumberland, Md		Address Route 3, Box 143 Cresap	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED May 15, 1966		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 19, 1966	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town or county) (State) near Cumberland, Maryland	
24. FUNERAL DIRECTOR John J. Hafer		25a. REC'D BY REGISTRAR MAY 20 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		Address (Street, city, town, or county) Cumberland, Md.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
Information from birth cert.										
06256					06252					
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN lb 2 DAYS 1 HR. 46 MIN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILEY FORD 85-3					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Twin II First DONALD Middle MARK Last KLIN					4. DATE OF DEATH MAY 1 19 66 Month MAY Day 1 Year 19 66					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH APRIL 29, 1966		9. AGE (In years last birthday) yrs. 2 IF UNDER 1 YEAR Months 2 Days 1 Hours 46 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Donald Ray Self					14. MOTHER'S MAIDEN NAME CHARLOTTE KLINE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 7735 IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Premature labor - 34 wks (c) Premature labor - 34 wks								INTERVAL BETWEEN ONSET AND DEATH 2 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 4/29 19 66 to 5/1 19 66 , that (I) (we) last saw the deceased alive on 4/29 19 66 and that death occurred at 12:45 P M, from causes and on the date stated above.										
22a. SIGNATURE Robert J. Dawson MD					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 2, 1966			
22c. PHYSICIAN'S NAME (Type) Dr. Robert J. Dawson, M.D.					22d. ADDRESS 500 Greene St., Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 2, 1966		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park			23d. LOCATION (City or Town) (County) (State) Cumberland Md.			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.					25a. REC'D BY REGISTRAR MAY 4 1966		25b. REGISTRAR'S SIGNATURE James F. Scarpelli			

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1 HR. 40 MIN. WILEY EDDO

COLUMBIANA

MEMORIAL HOSPITAL

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MARK

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WHITE

APRIL 20, 1908

CINCINNATI, MO.

CHARLOTTE KLINE

MEMORIAL HOSPITAL, CINCINNATI, MO.

12:45 P

MAY 1 1908

CERTIFICATE OF DEATH

06257

06253

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WEST VIRGINIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILEY FORD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Twin I RONALD LYNN KLINE		4. DATE OF DEATH Month MAY Day 1 Year 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 29, 1966
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	9. AGE (In years last birthday) yrs. 2 IF UNDER 1 YEAR Months 2 Days 1 Hours 53
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Donald Ray Self		14. MOTHER'S MAIDEN NAME CHARLOTTE KLINE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO (b) Prematurity DUE TO (c) Premature labor - 34 wks Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/29 , 19 66 , to 5/1 , 19 66 , that (I) (we) last saw the deceased alive on 5/1 , 19 66 , and that death occurred at 12:50 PM. from causes and on the date stated above.			
22a. SIGNATURE Robert J. Dawson M.D.		22b. DATE SIGNED 5/1/66	
22c. PHYSICIAN'S NAME (Type) Dr. Robert J. Dawson, M.D.		22d. ADDRESS 500 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 2, 1966	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Md.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR MAY 4 1966	25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and may be removed within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH					
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
06258 CERTIFICATE OF DEATH 06254					
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 8 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 328 FAYETTE ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle G. Last KREMER			4. DATE OF DEATH Month MAY Day 11 Year 1966		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 10-24-1896		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME HOWARD GETINGER		
14. MOTHER'S MAIDEN NAME META BLOCK			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		
16. SOCIAL SECURITY NO. UNKNOWN			17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Uterus DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from January 5, 1966 to May 11, 1966 , that (I) (we) last saw the deceased alive on May 10, 1966 , and that death occurred at 11:00 PM , from causes and on the date stated above.			
22a. SIGNATURE DR. BLANE SCHINDLER		22b. DATE SIGNED 5-13-66		22c. PHYSICIAN'S NAME (Type) DR. BLANE SCHINDLER	
22d. ADDRESS 43 GREENE ST.		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			
23b. DATE THEREOF MAY 14, 1966		23c. NAME OF CEMETERY OR CREMATORY ELMWOOD CEMETERY		23d. LOCATION (City or Town) _____ (County) _____ (State) _____ SHEPHERDSTOWN, W. VA.	
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR MAY 16 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge					

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DEPARTMENT OF DEFENSE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

06259

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06255

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westernport c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 133 Front Street		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) McCoole d. STREET ADDRESS C/O Charles Boehmes e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Davis Last Lahman		4. DATE OF DEATH Month May Day 28 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May. 21, 1876
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 7 Days 7 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mechanic		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.	
11. BIRTHPLACE (County & State, or foreign country) Medley, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham Lahman		14. MOTHER'S MAIDEN NAME Nancy Jane McDonald	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Waneta Uhler		Address Baltimore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia (c) Arteriosclerosis, Cardiac, Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH (Daughter)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-1- , 19 65 , to 5-31 , 19 66 , that (I) (we) last saw the deceased alive on 5-20 , 19 66 , and that death occurred at 1:35 P.M. from the causes and on the date stated above.			
22a. SIGNATURE R. W. Bess, Jr.		22b. DATE SIGNED 5-31-66	
22c. PHYSICIAN'S NAME (Type) R. W. Bess, Jr. M. D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-31-66	
23c. NAME OF CEMETERY OR CREMATORY Queens Point Cemetery		23d. LOCATION (City, town or county) (State) Keyser, W. Va.	
24. FUNERAL DIRECTOR Thomas Smith Jr.		25a. REC'D BY REGISTRAR JUN 2 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06260

06256

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 232 N. Centre St		d. STREET ADDRESS 232 N. Centre St	
3. NAME OF DECEASED (Type or print) Jessie Elizabeth Leasure		4. DATE OF DEATH May 4 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1889
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Frank Shanholtzer		14. MOTHER'S MAIDEN NAME Almeda Durst	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Margaret Leasure, 232 N. Centre St. Cumberland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Carcinomatosis, generalized 154X DUE TO Carcinoma of Rectum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 4, 1966	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		22. DATE SIGNED May 4, 1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 7, 1966	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR John J. Hafer		25a. REC'D BY REGISTRAR MAY 9 1966	
ADDRESS 230 Balto Ave., Cumberland, Md		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Remedios Sittler, M.D.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND-STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
06261					06257				
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miners Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lonaconing d. STREET ADDRESS Main Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Elizabeth First Middle Last 4. DATE OF DEATH May 4 19 66 Month Day Year					5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH May 16. 1889 9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Lonaconing, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME Ejkiel Duckworth 14. MOTHER'S MAIDEN NAME Margaret Stewart				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Althea Stakem Address Lonaconing, Md.					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PRIMARY CARCINOMA LIVER 1550 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS ARTERIOSCLEROSIS 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					21. I certify that (I) (this hospital) attended the deceased from 1956 to MAY 4, 1966 , that (I) (we) last saw the deceased alive on MAY 3, 1966 , and that death occurred at 10 A.M. from the causes and on the date stated above. 22a. SIGNATURE L.R. Miles, Jr. M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D. 22d. ADDRESS LONA CONING, MD. 22b. DATE SIGNED 5.5.66				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5/7/66 23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery 23d. LOCATION (City, town or county) (State) Lonaconing, Md.					24. FUNERAL DIRECTOR George Eichhorn ADDRESS Lonaconing, Md. 25a. REC'D BY REGISTRAR MAY 9 1966 25b. REGISTRAR'S SIGNATURE f Charles Judge				

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Allegheny

Maryland

Lonsomine

Main Street

May

Louis

May 16, 1889

70

Lonsomine, Maryland

U.S.A.

Margaret Stewart

Elizabeth

Mr. John Stoken

Lonsomine, Md.

Daughter

5/7/80

Burial

Oak Hill Cemetery

George Richmond

Lonsomine, Md.

1889

Lonsomine, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH					
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
06262			CERTIFICATE OF DEATH		
06258					
1. PLACE OF DEATH a. COUNTY ALLEGANY CO. MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 34 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT.#1 FLINTSTONE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WADE Middle S. Last LITTLEFIELD			4. DATE OF DEATH Month MAY Day 9 Year 19 66		
5. SEX M	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 6-16-1893		9. AGE (In years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CELANESE EMPLOYEE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) FLINTSTONE, MARYLAND	
13. FATHER'S NAME JAMES LITTLEFIELD			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 203-07-1454		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Uremia DUE TO (b) Hypertensive Arteriosclerosis DUE TO (c) Cardiovascular Disease					INTERVAL BETWEEN ONSET AND DEATH Since 4-5-66
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8.8.1966 to 5.9.1966 that (I) (we) last saw the deceased alive on 5.9.1966 and that death occurred at 1:05 AM from causes and on the date stated above.					
22a. SIGNATURE Wm. F. Williams MD			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-10-66
22c. PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS			22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/11/66	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Alleg Maryland
24. FUNERAL DIRECTOR ADDRESS Ruth E. Silcox Cumberland, Maryland 21502			25a. REC'D BY REGISTRAR DATE MAY 12 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge

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CERTIFICATE OF DEATH

ALLIANCE CO. CUMBERLAND

WADSWORTH S. LITTLEFIELD

DECEASED

JAMES LITTLEFIELD

MEMORIAL HOSPITAL, CUMBERLAND

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MAY 12 1966

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06263

06259

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
c. LENGTH OF STAY IN 1b Years		d. STREET ADDRESS Bowmans Addition	
d. NAME OF HOSPITAL DR INSTITUTION (if not in hospital, give street address) Bowmans Addition		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walter Middle Edward Last Livingood		4. DATE OF DEATH May 18 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1903
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR: Months 18 Days 18 Hours 18 Min. 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Truman Franklin Livingood		14. MOTHER'S MAIDEN NAME Quillia Frances Albright	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW 2		16. SOCIAL SECURITY NO.	
17. INFORMANT Donald Miller, Route 1, Cumberland, Md.		Address Bowmans Addition	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis (c) Coronary Sclerosis			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		M.D. Benedict Skitarelic, M.D.	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		22. DATE SIGNED May 17, 1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 21, 1966	
23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Park		23d. LOCATION (City, town or county) (State) Near Cumberland, Maryland.	
24. FUNERAL DIRECTOR John J. Hafer		ADDRESS 230 Balto Ave. Cumberland, Md.	
25a. REC'D BY REGISTRAR MAY 20 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06264					06260				
1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing c. LENGTH OF STAY IN 1b 2 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kyle Nursing Home					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton d. STREET ADDRESS 01-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) William Joseph Logsdon			4. DATE OF DEATH Month May Day 23 Year 1966						
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 4, 1889	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William T. Logsdon			14. MOTHER'S MAIDEN NAME Mary Ann McGimpsey						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 181-10-4079		17. INFORMANT J. Joseph Howell		Address Barton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lungs 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 1 Year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 15, 1966 , to May 23, 1966 , that (I) (we) last saw the deceased alive on May 17, 1966 , and that death occurred at 7 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Paul R. Wilson		22b. DATE SIGNED May 24, 1966							
22c. PHYSICIAN'S NAME (Type) Paul R. Wilson, M.D.		22d. ADDRESS Piedmont, West Virginia							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/25/66		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION (City, town or county) (State) Moscow Mills, Md.			
24. FUNERAL DIRECTOR G. Boel		ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR MAY 26 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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CERTIFICATE OF DEATH

06265

06261

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		b. COUNTY ALLEGANY	
c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 706 SHRIVER AVE.	
3. NAME OF DECEASED (Type or print) First JOSEPH		Last MACKERT	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-6-1897	
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward A. Mackert		14. MOTHER'S MAIDEN NAME Agnes Logsdon (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 211-05-5342	
17. INFORMANT PATIENT'S CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) _____ DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April , 19 66 , to May , 19 66 , that (I) (we) saw the deceased alive on 5/18 , 19 66 , and that death occurred at 9:45 M, from causes and on the date stated above			
22a. SIGNATURE Leo H. Lee Jr.		22b. DATE SIGNED 5/15/66	
22c. PHYSICIAN'S NAME (Type) Leo H. Lee Jr.		22d. ADDRESS 456 N. Centre St. Cumberland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/18/66	
23c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Alleg Maryland	
24. FUNERAL DIRECTOR H. Lee Silcox		25. MAY 18 1966 DATE	
26. ADDRESS Cumberland Maryland 21502		27. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1353

2252

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06266

CERTIFICATE OF DEATH

06262

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Mineral</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>30 min.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hosp.</u>		d. STREET ADDRESS <u>Rt. 1 Along St. Rt. # 28</u>	
3. NAME OF DECEASED (Type or print) <u>Lawrence Junior Maxson</u>		4. DATE OF DEATH <u>5</u> Month <u>14</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-27-1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ins. Agent Metropolitan Ins. Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Elkins, W. Va.</u>	
13. FATHER'S NAME <u>Jacob R. Maxson</u>		14. MOTHER'S MAIDEN NAME <u>Lestie M. Wolfe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>W. W. # 2</u>		16. SOCIAL SECURITY NO. <u>217-10-5678</u>	
17. INFORMANT <u>Mrs. Esther R. Maxson</u>		Address <u>Rt. # 1 Ridgeley, W. Va.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive C.V. Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>with coronal hemorrhage & infarct</u> DUE TO (c) <u>Pulmonary Edema</u> 2-3 hours		INTERVAL BETWEEN ONSET AND DEATH <u>approx</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>66</u> to <u>May 18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 14</u> , 19 <u>66</u> , and that death occurred at <u>5/18/66</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Blane M. Schindler</u>		22b. DATE SIGNED <u>5/17/66</u>	
22c. (PHYSICIAN'S NAME (Type) <u>Blane M. Schindler, M. D.</u>		22d. ADDRESS <u>43 Greene St. Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/18/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Maplewood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Elkins, Randolph Co. W. Va.</u>	
24. FUNERAL DIRECTOR <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Maryland</u>	
25a. REC'D BY REGISTRAR <u>MAY 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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Handwritten notes and signatures, including a large signature in the center.

Handwritten text at the bottom left, possibly a date or reference number.

06267

CERTIFICATE OF DEATH

06263

1. PLACE OF DEATH COUNTY ALLEGANY STATE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W.VA. b. COUNTY Grant	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 22XHRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 15 EAST AVE.	
3. NAME OF DECEASED (Type or print) First LEONARD Middle BOYD Last MC DONALD		4. DATE OF DEATH Month MAY Day 21 Year 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 20, 1966
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 22 Min.
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID C. MC DONALD		14. MOTHER'S MAIDEN NAME HELEN A SWICK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD/		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7615 Prematurity DUE TO (b) Removal rupture of membranes DUE TO (c) Removal rupture of membranes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 1:30 PM from causes and on the date stated above.			
22a. SIGNATURE Dr. Americo Valdes		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. AMERICO VALDES		22d. ADDRESS ALGONQUIN HOTEL, CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-22-66	23c. NAME OF CEMETERY OR CREMATORY N. Mill Creek	23d. LOCATION (City or Town) (County) (State) Dorcas Grant W.Va.
24. FUNERAL DIRECTOR Arnold Fun. Home		25a. REC'D BY REGISTRAR Petersburg, W.Va. MAY 27 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please to move carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

65283

CENTRAL CLINIC

65283

W.VA. PETERSBURG 25TH ST. 11 EAST AVE. MEMORIAL HOSPITAL

MAY 21 LEONARD BOYD MC DONALD
MAY 20, 1966
CUMBERLAND, MD. U.S.A.
HELEN A SWICK
MEMORIAL HOSPITAL, CUMBERLAND, MD.

1.30PM
ALLEGANY VALLEY
MAY 21 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
06268					06264					
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>			c. LENGTH OF STAY IN 1b <u>2 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pinto</u>			01-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Miners Hospital</u>					d. STREET ADDRESS <u>Route 6 Box 111</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Iva</u> Middle <u>Irene</u> Last <u>McElwee</u>					4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 18, 1895</u>		9. AGE (in years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		
13. FATHER'S NAME <u>Irvin Lohr</u>					14. MOTHER'S MAIDEN NAME <u>Emma Lohr</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Franklin J. McElwee, Route 5, Box 323J</u>			Address <u>Cumberland, Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute generalized peritonitis</u> 1750 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Pelvic carcinomatosis, ovarian</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 year</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1966</u> to <u>May 12, 1966</u> that (I) (we) last saw the deceased alive on <u>May 12, 1966</u> , and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>A. Paige Strong</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>May 13, 1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>A. Paige Strong, M.D.</u>					22d. ADDRESS <u>Grantsville, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 16, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>			23d. LOCATION (City, town or county) (State) <u>Cumberland, Md</u>			
24. FUNERAL DIRECTOR <u>John J. Hafer</u>					ADDRESS <u>230 Balto Ave., Cumberland Md</u>		25a. REC'D BY REGISTRAR <u>May 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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CERTIFICATE OF DEATH

06269

06265

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 12 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 826 BUCKINGHAM ROAD	
3. NAME OF DECEASED (Type or print) First Middle Last DANIEL FRANCIS MC MULLEN		4. DATE OF DEATH Month Day Year MAY 15, 19 66.	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-1-1891
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney	
11. BIRTHPLACE (County & State, or foreign country) MT. SAVAGE, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HUGH A. MC MULLEN		14. MOTHER'S MAIDEN NAME ANNA M. MULLEDY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes, W. W. # 1		16. SOCIAL SECURITY NO. 217-10-7433	
17. INFORMANT MEMORIAL HOSPITAL- CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INFARCTION SMALL INTESTINE DUE TO MESENTERIC OCCLUSION (b) DUE TO ARTERIOSCLEROSIS (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 5 day 5 day 5 day?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) LYMPHO SARCOMA		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19 50 , to 5/15 , 19 66 , that (I) (we) last saw the deceased alive on 5/15 , 19 66 , and that death occurred at 5:45 P.M. on 5/16 , 19 66 , and on the date stated above.			
22a. SIGNATURE <i>S. G. Weisman</i>		22b. DATE SIGNED 5/16/66	
22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN		22d. ADDRESS 59 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/18/66	
23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cem.		23d. LOCATION (City or Town) (County) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland		25a. REC'D BY REGISTRAR MAY 23 1966	
25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

12 DAYS

CUMBERLAND

628 BUCKINGHAM ROAD

MEMORIAL HOSPITAL

12, 01

WAY

MC HULLEN

WHITE

DANIEL

2-1-1931

WHITE

U. S. A.

MT. SAVAGE, MD.

JAMES H. MULLEN

JAMES H. MULLEN

MEMORIAL HOSPITAL - CUMBERLAND, MD.

1-12-31

52 GREENE ST., CUMBERLAND, MD.

DR. J. G. WEISMAN

MAY 3 1938

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)
SM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06270

06266

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 78 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 464 Columbia Street				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 464 Columbia Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Joseph		First Joseph		Middle E.		Last Metz		4. DATE OF DEATH Month May Day 25 Year 19 66	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 11, 1887		9. AGE (in years last birthday) 78 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman				10b. KIND OF BUSINESS OR INDUSTRY Contracting Co.		11. BIRTHPLACE (State or foreign country) Cumberland Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Metz				14. MOTHER'S MAIDEN NAME Deema Robinette					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Mary Sweitzer		17. INFORMANT 464 Columbia St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE: Benedict Skitarelic				M.D.		22. DATE SIGNED May 25, 1966			
EXAMINER'S NAME (Type) Benedict Skitarelic MD				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Cumberland Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 23, 1966		23c. NAME OF CEMETERY OR CREMATORY Hill Crest Burial Park		23d. LOCATION (City, town or county) (State) Cumberland Maryland			
24. FUNERAL DIRECTOR Louis Stein Inc. Cumberland Md				25a. REC'D BY REGISTRAR MAY 31 1966		25b. REGISTRAR'S SIGNATURE Charles J. Judge			

MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2270

County of ... State of ...
City of ...
I, the undersigned, a duly qualified Medical Examiner, do hereby certify that on the ... day of ... 19... at ...
the body of ... was found ...
and that the cause of death was ...

Witness my hand and seal this ... day of ... 19...
at ...
Medical Examiner

[Faint, illegible text and signatures follow, likely representing the deceased and witnesses.]

06271

CERTIFICATE OF DEATH

06267

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG c. LENGTH OF STAY IN 1b 15 MINS. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG d. STREET ADDRESS 30 E. COLLEGE AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle J. Last MILLER		4. DATE OF DEATH Month MAY Day 3 Year 19 66	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 14, 1897 9. AGE (In years last birthday) 68 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MATTHEW JONES		14. MOTHER'S MAIDEN NAME MARY WADELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213-05-7130A	
17. INFORMANT EARL R. MILLER, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-vascular disease DUE TO (c) 6 yrs		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Obesity		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-10 , 19 60 , to 5-3 , 19 66 , that (I) (was) last saw the deceased alive on 5-2 , 19 66 , and that death occurred at 11 P.M. from causes and on the date stated above.			
22a. SIGNATURE H.C. Diehl M.D.		22b. DATE SIGNED 5/5/66	
22c. PHYSICIAN'S NAME (Type) H. C. DIEHL, M. D.		22d. ADDRESS W. MAIN ST., FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAY 6, 1966	23c. NAME OF CEMETERY OR CREMATORY FB'G. MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		25a. REC'D BY REGISTRAR MAY 9 1966	25b. REGISTRAR'S SIGNATURE J. Charles Judge

08373

CERTIFICATE OF DEATH

08373

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-2001 BY 60322 UCBAW

DATE 10-10-2001 BY 60322 UCBAW

1. NAME OF DECEASED

1. NAME OF DECEASED

2. SEX

3. RACE

2. SEX

3. RACE

4. DATE OF BIRTH

5. PLACE OF BIRTH

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

6. DATE OF DEATH

7. PLACE OF DEATH

9. SIGNATURE OF DECEASED

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESSES

12. DATE OF DEATH

13. PLACE OF DEATH

14. CAUSE OF DEATH

12. DATE OF DEATH

13. PLACE OF DEATH

15. SIGNATURE OF DECEASED

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF DECEASED

15. SIGNATURE OF DECEASED

16. SIGNATURE OF WITNESSES

18. DATE OF DEATH

19. PLACE OF DEATH

20. CAUSE OF DEATH

18. DATE OF DEATH

19. PLACE OF DEATH

21. SIGNATURE OF DECEASED

22. SIGNATURE OF WITNESSES

23. SIGNATURE OF DECEASED

21. SIGNATURE OF DECEASED

22. SIGNATURE OF WITNESSES

24. DATE OF DEATH

25. PLACE OF DEATH

26. CAUSE OF DEATH

24. DATE OF DEATH

25. PLACE OF DEATH

27. SIGNATURE OF DECEASED

28. SIGNATURE OF WITNESSES

29. SIGNATURE OF DECEASED

27. SIGNATURE OF DECEASED

28. SIGNATURE OF WITNESSES

30. DATE OF DEATH

31. PLACE OF DEATH

32. CAUSE OF DEATH

30. DATE OF DEATH

31. PLACE OF DEATH

33. SIGNATURE OF DECEASED

34. SIGNATURE OF WITNESSES

35. SIGNATURE OF DECEASED

33. SIGNATURE OF DECEASED

34. SIGNATURE OF WITNESSES

36. DATE OF DEATH

37. PLACE OF DEATH

38. CAUSE OF DEATH

36. DATE OF DEATH

37. PLACE OF DEATH

39. SIGNATURE OF DECEASED

40. SIGNATURE OF WITNESSES

41. SIGNATURE OF DECEASED

39. SIGNATURE OF DECEASED

40. SIGNATURE OF WITNESSES

42. DATE OF DEATH

43. PLACE OF DEATH

44. CAUSE OF DEATH

42. DATE OF DEATH

43. PLACE OF DEATH

45. SIGNATURE OF DECEASED

46. SIGNATURE OF WITNESSES

47. SIGNATURE OF DECEASED

45. SIGNATURE OF DECEASED

46. SIGNATURE OF WITNESSES

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any fee is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06272

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06268

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg	
c. LENGTH OF STAY IN 1b Lifetime		d. STREET ADDRESS 184 Ormond Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 184 Ormond Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elmer		4. DATE OF DEATH May 7 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 10, 1890
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days 10. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal	
11. BIRTHPLACE (State or foreign country) Hoffman, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Miller		14. MOTHER'S MAIDEN NAME Jane Lewis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) CORONARY Sclerosis (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED May 7, 1966	
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE Benedict Skitarelic M.D.		Address (Street, city, town, or county) Cumberland, Md.	
EXAMINER'S NAME (Type) Benedict Skitarelic MD		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF May 10 1966		22c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park	
22d. LOCATION (City, town, or country) Frostburg Md.		24a. REC'D BY REGISTRAR May 12 1966	
23. FUNERAL DIRECTOR Hafer Funeral Home, 60 W. Main St		24b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

1

06273

CERTIFICATE OF DEATH

06269

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN lb 8 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 224 COLE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LAWRENCE J. MILLER		4. DATE OF DEATH Month Day Year MAY 17 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 28, 1880
9. AGE (In years last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Celanese Worker	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISAAC MILLER		14. MOTHER'S MAIDEN NAME LUCINDA STREET	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Navy Mexican War		16. SOCIAL SECURITY NO. 214-07-2284	
17. INFORMANT Nellie G Miller		Address 224 Cole St Cumb'd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest - 4331 DUE TO (b) Pulmonary Embolism DUE TO (c) Coronary Thrombosis due to Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1957 , 19__, to May , 19 66 , that (I) (we) last saw the deceased alive on May 17 , 19 66 , and that death occurred at 7:00 A.M. from causes and on the date stated above.			
22a. SIGNATURE G. Overton Himmelwright		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/19/66
22c. PHYSICIAN'S NAME (Type) G. OVERTON HIMMELWRIGHT		22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 20, 1966	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md
24. FUNERAL DIRECTOR John J. Hafer		25a. REC'D BY REGISTRAR MAY 23 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2252

ALLEGY

ALL-EGGY

2448 3

01A-192340-2

254 GOLF STREET

FEMUR: ALL HOSPITAL

0821, 85.7438

2714

336 *Journal of Management Education* 26(3)

244 ALMODOVAR ET AL.

CERTIFICATE OF DEATH

06275

06271

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. VA. b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2½ HOURS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle A. Last MYERS		4. DATE OF DEATH Month MAY Day 26 Year 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-20-03
9. AGE (In years last birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shift Supervisor	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shift Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Celanese	
11. BIRTHPLACE (County & State, or foreign country) PURGITTSTVILLE, WVA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CRAWFORD B. MYERS		14. MOTHER'S MAIDEN NAME SARAH T. SIMPSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-07-6563	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH acute	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 11, 1965 , to May 26, 1966 , that (I) (we) last saw the deceased alive on May 26, 1966 , and that death occurred at 10:30, 10 AM hours and on the date stated above.			
22a. SIGNATURE Clay E. Durrett		22b. DATE SIGNED 5/27/66	
22c. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT		22d. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/28/66	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Alleg., Md.
24. FUNERAL DIRECTOR 121 Memorial Ave., Cumb., Md.		25a. REC'D BY REGISTRAR JUN 3 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06272

TESTIFICATE OF DEATH

06272

ALLEGANY

W. VA.

W. VA.

COM. ENCLAND

ST. HUBBS

FORT ASHER

MEMORIAL HOSPITAL

ROBERT

MYERS

MAY

2-20-02

MALE WHITE

PURITTSVILLE, W. VA.

CRAWFORD S. MYERS

SARAH T. SIMPSON

MEMORIAL HOSPITAL - COMBLED, W. VA.

ST. HUBBS

DR. CLAY E. DUNN

336 VIRGINIA AVE., COMBLED, MD.

JUN 1 1966

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06276		06272	
1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 17 Fifth St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First John Middle W. Last Nealis		4. DATE OF DEATH Month May Day 5 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1901
9. AGE (In years) Last birthday 64 yrs.		IF UNDER 1 YEAR Months 01 Days 1	IF UNDER 24 HRS. Hours 00 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Hampshire County, W.Va.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph M. Nealis	
14. MOTHER'S MAIDEN NAME Maggie Haines		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Harry E. Nealis, Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Coronary Sclerosis With Thrombosis Left. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Edema, Marked		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED May 5, 1966		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 5, 1966	
Address (Street, city, town, or county) Rt. 9 Cumberland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 8, 1966	23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery	23d. LOCATION (City or Town) (County) (State) Fort Ashby, W. Va.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE MAY 10 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

1903

1903

1903

CERTIFICATE OF DEATH

06277

06273

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 01-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				d. STREET ADDRESS 396 BOWLING AVE, BOWLING GREEN			
3. NAME OF DECEASED (Type or print) First Middle Last BRIAN WILLIAM NORRIS				4. DATE OF DEATH Month Day Year MAY 22 1966			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-9-66	
9. AGE (In years lost birthday) 0 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (infant)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME LESTER NORRIS		14. MOTHER'S MAIDEN NAME DELPHINE (RICE) NORRIS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Lester R. Norris 396 Bowling Ave. PT'S CHART Bowling Green, Cumb. Md.			
18. CAUSE OF DEATH (Enter only one cause per line of (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacterial Pneumonia DUE TO 5710 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Enteritis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 18 , 19 66 , to May 22 , 19 66 , that (I) (we) last saw the deceased alive on May 19 , 19 66 , and that death occurred at 8:00 AM , from causes on and on the date stated above.							
22a. SIGNATURE DR. B. SCHINDLER, M.D.				22b. DATE SIGNED 5/23/66		22c. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER, M.D.	
22d. ADDRESS 43 GREENE ST, CUMBERLAND, MARYLAND.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/24/66		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR H. Wayne George				25a. REC'D BY REGISTRAR MAY 26 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6530

STATE OF TEXAS

1933

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JAN 13 1933

JAN 13 1933

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06278

06274

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 55 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hazen Road		d. STREET ADDRESS Hazen Road	
3. NAME OF DECEASED (Type or print) First George Middle Perry Last O'Neal, Jr.		4. DATE OF DEATH Month May Day 13 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1910
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Lumber	9. AGE (In years last birthday) yrs. 55
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George P. O'Neal		14. MOTHER'S MAIDEN NAME Iga Mae Bucy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-05-7624	
17. INFORMANT Mrs. Lena O'Neal, Cumberland, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, Generalized DUE TO (b) Carcinoma of Pancreas DUE TO (c) 157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED May 13, 1966		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Charles Judge Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 15, 1966	23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland, Md.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR MAY 23 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in the space provided for the signature of the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1055

RECEIVED MAY 12 1964

1055

1055

MAY 12 1964

CERTIFICATE OF DEATH

06275

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 16 ELDER ST.	
3. NAME OF DECEASED (Type or print) CHARLES R. PENNER		4. DATE OF DEATH Month MAY Day 14 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-17-1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Conductor		10b. KIND OF BUSINESS OR INDUSTRY Railroad	9. AGE (In years last birthday) yrs. 82
11. BIRTHPLACE (County & State, or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John SAMUEL PENNER		14. MOTHER'S MAIDEN NAME MARY LOUISE MILLER BRASH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 4221 DUE TO (b) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH 4d
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/10 , 19 66 , to 5/14 , 19 66 that (I) (we) lost the deceased on 5/13 , 19 66 , and that death occurred at 2-40AM from causes on the date stated above.			
22a. SIGNATURE William P. James		22b. DATE SIGNED 5/17/66	
22c. PHYSICIAN'S NAME (Type) DR. W. P. JAMES		22d. ADDRESS 441 N. CENTRE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 16, 1966	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR MAY 19 1966	25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100273

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ALLIANCE

MARYLAND

ALLIANCE

CUMBERLAND

100273

CUMBERLAND

ALLIANCE

MEMORIAL HOSPITAL

POWER

POWER

1-11-1902

1-11-1902

WASHINGTON DC

WASHINGTON DC

MARY LOUISE KILPATRICK

MARY LOUISE KILPATRICK

MEMORIAL HOSPITAL, CUMBERLAND, MD

MEMORIAL HOSPITAL, CUMBERLAND, MD

100273

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TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06280

06276

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG				c. LENGTH OF STAY IN 1b LIFETIME			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 162 EAST COLLEGE AVENUE				d. STREET ADDRESS 162 E. COLLEGE AVE.			
3. NAME OF DECEASED (Type or print) DAVID H. PLUMMER				4. DATE OF DEATH Month MAY Day 21 Year 19 66			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 10, 1888	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWN MACHINE SHOP		11. BIRTHPLACE (County & State, or foreign country) SHAFT, MARYLAND	
10b. KIND OF BUSINESS OR INDUSTRY MACHINE SHOP		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME DAVID PLUMMER		14. MOTHER'S MAIDEN NAME CARRIE SEATON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. DAVID PLUMMER, 162 E. COLLEGE AVE.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Congestive Heart failure 4500 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 1 week years -	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 19 61 to May 21, 19 66 that (I) (was) last saw the deceased alive on May 20 19 66 and that death occurred at 3:45 PM from the causes and on the date stated above.							
22a. SIGNATURE John B. Davis, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/24/66	
22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M.D.				22d. ADDRESS 2 BROADWAY, FROSTBURG, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 24, 1966		23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK		23d. LOCATION (City, town or county) (State) FROSTBURG, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE HAFFER FUNERAL HOME, 60 W. MAIN ST.				25a. REC'D BY REGISTRAR MAY 31 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

1927

ALLEGANY

FROSTBURG

162 EAST COLLEGE AVENUE

DAVID

H.

X

WHITE

HAIR

OWN MACHINE SHOP

MACHINE SHOP

SHIRT, MARYLAND

U.S.A.

DAVID PLUMMER

CARRIE BRATON

HOME

MRS. DAVID PLUMMER

FROSTBURG, MD.
162 E. COLLEGE AVE.

ALLEGANY

MARYLAND

FROSTBURG

LIFESTIME

162 E. COLLEGE AVE.

PLUMMER

MAY

SI

66

GRIMAL

JOHN E. DAVIS, M.D.

2 BROADWAY, FROSTBURG, MD.

MAY 24, 1966 FROSTBURG MEM. PARK FROSTBURG, MARYLAND

MARYLAND

FROSTBURG, MD.

MAY 31 1966

Gravestone

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

06281

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06277

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA VALE,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3 SPRINGFIELD BOULEVARD			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First GLORIA Middle JEAN Last RADABAUGH			4. DATE OF DEATH Month MAY Day 6th Year 19 66		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 15th, 1934	9. AGE (In years last birthday) 31 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACH. OP., CONING DEPT.		10b. KIND OF BUSINESS OR INDUSTRY CELANESE CORP.		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME FRANCIS BLANK			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			14. MOTHER'S MAIDEN NAME MARY C. HUNT		
16. SOCIAL SECURITY NO. 219-32-4106			17. INFORMANT Address FRANCIS BLANK, MT. SAVAGE, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemothorax, bilateral; perforation of lungs and great vessels Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c) Gunshot					INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by husband			
20c. TIME OF INJURY Month, Day, Year 3:05 p.m. 5-6 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
		20f. (City or town) (County) (State) Cumberland Alleg, Md			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic, MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		Address (Street, city, town, or county) Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 10, 1966		23c. NAME OF CEMETERY OR CREMATORY ST. GEORGE'S CEMETERY	
				23d. LOCATION (City or Town) (County) (State) MT. SAVAGE, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR.,		ADDRESS FROSTBURG, MD.		25a. RECD BY REGISTRAR MAY 11 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

06282

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06278

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 10 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3 Springfield Blvd		d. STREET ADDRESS 3 Springfield Blvd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Richard Hamilton Radabaugh			4. DATE OF DEATH Month Day Year May 6 19 66		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH August 22, 1918		9. AGE (In years lost, birthday) yrs. 47
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee of Kelly S Tire Company		10b. KIND OF BUSINESS OR INDUSTRY Tire Company		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME William Sturm (Deceased)			14. MOTHER'S MAIDEN NAME Ruby Radabaugh		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 213-24-7322		17. INFORMANT Address Mrs. Lois R. Small Cumberland, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun blast of head DUE TO (b) (Self Inflicted) DUE TO (c) (Self Inflicted) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic		M.D.		22. DATE SIGNED May 6, 1966	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		Address (Street, city, town, or county) Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/8/66		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	
				23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland	
24. BURIAL DIRECTOR ADDRESS Ruth E. Silcox Cumberland Maryland 21502		25a. RECD BY REGISTRAR MAY 9 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

1938

1938

MAY 11 1938

06283

CERTIFICATE OF DEATH

06279

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 year	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SYLVAN RETREAT		d. STREET ADDRESS 305 Central Avenue	
3. NAME OF DECEASED (Type or print) First Lottie Middle Reed Last Riley		4. DATE OF DEATH Month May Day 12 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/5/85
9. AGE (In years lost birthday) yrs. 81		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James W. Byran		14. MOTHER'S MAIDEN NAME Ella Griffin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Walter Riley-Westernport, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Hypertension ch. degenerative DUE TO (b) ② Cerebral apoplexy - DUE TO (c) ③ 17:11 Severe psychosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 13, 19 65 , to May 12, 1966 , that (I) (we) last saw the deceased alive on May 12, 19 66 , and that death occurred at 9 A.M. from causes on the date stated above.			
22a. SIGNATURE L. B. Mathews		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) L. B. Mathews, M.D.		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/15/66	23c. NAME OF CEMETERY OR CREMATORY Philos	23d. LOCATION (City or Town) (County) (State) Westernport -Alto. Md.
24. FUNERAL DIRECTOR Ed Boul		25a. REC'D BY REGISTRAR MAY 16 1966	
ADDRESS Westernport, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0553

RECEIVED

0553

Major R. H. Westmoreland, Jr.

MAY 16 1962

Westmoreland, Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
06284 1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					06280 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN IB 10/22/64		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland			d. STREET ADDRESS 222 Bond Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Allegany County Infirmary							e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Emma Catherine Ritter					4. DATE OF DEATH May 9, 1966				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/29/1869		9. AGE (In years last birthday) 97 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress at home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Adam Ritter					14. MOTHER'S MAIDEN NAME Elizabeth Ewald				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. None.		17. INFORMANT P.O.Box 599, Address Cumberland, Md. Allegany County Infirmary records.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis 4221 DUE TO myocarditis & decompensation (b) DUE TO Arteriosclerosis (c)									INTERVAL BETWEEN ONSET AND DEATH 4 hrs 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 10/22/64 , 19__, to 5/9/66 , 19__, that (I) (we) last saw the deceased alive on 5/7/1966 , 19__, and that death occurred at A. M., from the causes and on the date stated above.									
22a. SIGNATURE Clay E. Durrett					22b. DATE SIGNED 5/9/1966		22c. PHYSICIAN'S NAME (Type) Clay E. Durrett, N. D.		
					22d. ADDRESS 236 Virginia Avenue, Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/11/66		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.		23d. LOCATION (City, town or county) (State) Cumb. Md.			
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.					25a. REC'D BY REGISTRAR MAY 12 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

УДК 62-50

SECRET

SECRET

White House

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Ans: 17, Ans: 17

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Cliff W. Durrell, M. D.

5. Dostupnost, omezení a náklady

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

(M)

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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 7 Film G327 6/14/66 mh									
06285					06281				
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN lb 8 HRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS 113 WEST FIRST ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELLA Middle VIRGINIA Last RITZ			4. DATE OF DEATH Month MAY Day 30 Year 1966						
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 15, 1915		9. AGE (In years last birthday) yrs. 50	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HOWARD A. GRIMM					14. MOTHER'S MAIDEN NAME ELIZABETH REED				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiac Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Debate Mellitus								INTERVAL BETWEEN ONSET AND DEATH 2 days yes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1957 , 19____, to May , 19 66 , that (I) two lost saw the deceased alive on May 30 , 19 66 and that death occurred 100 A.M. , from causes on and on the date stated above.									
22a. SIGNATURE G. Overton Himmelwright 22c. PHYSICIAN'S NAME (Type) G. OVERTON HIMMELWRIGHT					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.			22b. DATE SIGNED 5/31/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 2, 1966		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park			23d. LOCATION (City or Town) (County) (State) Cumberland, Md. - Allegany		
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.					25a. REC'D BY REGISTRAR JUN 6 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

6883

RECORDS OF DEATH

1981

ALLEGANY
CUMBERLAND

MARYLAND
CUMBERLAND

8 hrs.

MEMORIAL HOSPITAL

113 WEST FIRST ST.

ELIZABETH REED

113

MAY 30

68

FEMALE WHITE

JULY 15, 1912

U.S.A.

CUMBERLAND, MD.

HOWARD A. GRIMM

ELIZABETH REED

MEMORIAL HOSPITAL, CUMBERLAND, MD.

RECEIVED
JUL 15 1912
U.S. DEPT. OF HEALTH
BUREAU OF VITAL STATISTICS
WASHINGTON, D.C.

may be retained in the hospital or attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

06286

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06282

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Life				d. STREET ADDRESS 01-1			
3. NAME OF DECEASED (Type or print) First Charles Middle Garfield Last Rizer				4. DATE OF DEATH Month May Day 17, 1966 Year 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 1, 1878	9. AGE (In years last birthday) yrs. 87	IF UNDER 1 YEAR Months 17 Days 19		IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kelly Springfield Employee			10b. KIND OF BUSINESS OR INDUSTRY Mt. Savage, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
11. BIRTHPLACE (State or foreign country) Mt. Savage, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Solomon Rizer				14. MOTHER'S MAIDEN NAME Rachel Weinknott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-05-9643		17. INFORMANT Address Miss Betty Rizer, Mt. Savage, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH 25 yrs.?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ✓					
20c. TIME OF INJURY Month, Day, Year Hour o. m. ✓ 19 p. m. ✓		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ✓		20f. (City or town) (County) (State) ✓	
21. I certify that (I) (this hospital) attended the deceased from SEPT. 1964 to 17 MAY 1966 that (I) (we) last saw the deceased alive on 17 MAY 1966 and that death occurred at 2 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Martin M. Rothstein M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/19/66	
22c. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN M.D.				22d. ADDRESS 48 BROADWAY - FROSTBURG - MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 20, 1966		23c. NAME OF CEMETERY OR CREMATORY Palto Alto Cemetery		23d. LOCATION (City, town, or county) (State) Hyndman, Pa. RD#1 Bedford Co.	
24. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Leigler				25a. REC'D BY REGISTRAR MAY 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

3833

3833

CHIEF
CLERK
MAY 1964

1
FOR STATE HEALTH DEPT. M

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06287

06283

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 6 Weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS Bel Aire	
3. NAME OF DECEASED (Type or print) First Nellie Middle Elisa Last Ruehl		4. DATE OF DEATH Month May Day 1 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 29, 1896
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Winebrenner		14. MOTHER'S MAIDEN NAME Ida Leasure	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-14-1379	
17. INFORMANT Thomas E. Ruehl		Address 425 Franklin Street Cumberland, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC MYOCARDITIS DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) ----- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarellic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED May 1, 1966		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/4/66	23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Gardens	23d. LOCATION (City or Town) (County) (State) LaVale Allegany Maryland
24. FUNERAL DIRECTOR Ruth E. Silcox Cumberland, Maryland		25a. REC'D BY REGISTRAR MAY 4 1966	25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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CERTIFICATE OF DEATH

06288

06284

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 16 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 19 HUMBERT ST	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First GEORGE Middle B. SAPP Last		4. DATE OF DEATH Month 5/25/66 Day 19 Year 19	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/14/05
9. AGE (In years last birthday) yrs. 61		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRIVER		10b. KIND OF BUSINESS OR INDUSTRY TAXI CAB	11. BIRTHPLACE (County & State, or foreign country) THOMAS, W. VA.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GEORGE B. SAPP	
14. MOTHER'S MAIDEN NAME LAURA BARRICK		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. 214 05 4368		17. INFORMANT PT'S CHART Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1621 IMMEDIATE CAUSE (a) Empyema DUE TO (b) Bronchogenic Carcinoma DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus, Hypertension			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/11 , 19 66 , to 5/25 , 19 66 that (I) (we) last saw the deceased alive on 5/24 , 19 66 , and that death occurred at 358 A from causes and on the date stated above.			
22a. SIGNATURE Dr. L. Ley		22b. DATE SIGNED 5/25/66	
22c. PHYSICIAN'S NAME (Type) DR. L. LEY		22d. ADDRESS 456 N. Centre	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAY 27, 1966	23c. NAME OF CEMETERY OR CREMATORY HYNDMAN CEMETERY	23d. LOCATION (City or Town) (County) (State) HYNDMAN, PA.
24. FUNERAL DIRECTOR BYRON KIGHT ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR JUN 3 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06289

06285

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. b. COUNTY Alleghany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.		c. LENGTH OF STAY IN 1b 2 Hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. STREET ADDRESS 8 Brook Street	
3. NAME OF DECEASED (Type or print) First Francis Middle Richard Last Sass		4. DATE OF DEATH Month May Day 15 Year 19 66	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/30/46
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY College	9. AGE (In years last birthday) 19 yrs.
11. BIRTHPLACE (State or foreign country) Swickley Valley, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis R. Sass		14. MOTHER'S MAIDEN NAME Louana M. Kopsa	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 171-36-2990	
17. INFORMANT Mr. Francis R. Sass		Address Coraopolis, Pa. 8 Brooke St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage 8254 DUE TO (b) Skull Fracture Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 20 M.
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Passenger in Auto Wreck	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12:30 May 15 1966		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumb. Airport		20f. (City or town) (County) (State) Wiley Ford, Mineral, W. Va.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 15, 1966 22. DATE SIGNED EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. Address (Street, city, town, or county) Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/18/66	
23c. NAME OF CEMETERY OR CREMATORY Coraopolis Cemetery		23d. LOCATION (City, town or county) (State) Coraopolis Allegheny Pa.	
24. FUNERAL DIRECTOR H. Wayne George		25a. REC'D BY REGISTRAR MAY 23 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18, and give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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AGE

RESIDENCE

DATE

CAUSE OF DEATH

PLACE OF DEATH

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MAY 23 1966

CERTIFICATE OF DEATH

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06286

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN lb 5 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS 40 WRIGHT STREET	
3. NAME OF DECEASED (Type or print) BLANCHE SAVAGE		4. DATE OF DEATH Month MAY Day 9 Year 19 66	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 22, 1894
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STENOGRAPHIC		10b. KIND OF BUSINESS OR INDUSTRY REFRACTORIES	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE M. SAVAGE		14. MOTHER'S MAIDEN NAME HARRIET MURPHY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 413-10-9901A	
17. INFORMANT OLIN SAVAGE, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Arrest 4330 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture, Left Femur, Intertrochanteric			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 4, 1966 , to May 9, 1966 , that (I) (we) last saw the deceased alive on May 9, 1966 , and that death occurred at 1050 AM , from causes and on the date stated above.			
22a. SIGNATURE Alvin J. Walters		22b. DATE SIGNED 5-11-66	
22c. PHYSICIAN'S NAME (Type) ALVIN WALTERS, M. D.		22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAY 12, 1966	23c. NAME OF CEMETERY OR CREMATORY FB'G. MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		24. DATE BY REGISTRAR MAY 16 1966	
24. REGISTRAR'S SIGNATURE John J. Judge			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
06292		CERTIFICATE OF DEATH	
06287			
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. VA. b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEYSER		d. STREET ADDRESS RT. 4, BOX 101	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BESSIE Middle P. Last SHOEMAKER		4. DATE OF DEATH Month MAY Day 3 Year 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-17-1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE (In years last birthday) 67 yrs.
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JAMES CHURCH		14. MOTHER'S MAIDEN NAME IDA JOHNSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of sigmoid 174 X DUE TO (b) Carcinoma of uterus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6-10 mo 10-11 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary edema & Cardiac failure - 12 hours		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-28-66 , 19 66 to 5-3 , 19 66 that (I) (we) last saw the deceased alive on 2/3 19 66 , and that death occurred at 2:28 AM from causes and on the date stated above.			
22a. SIGNATURE A. J. Mirkin		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. A. J. MIRKIN		22d. ADDRESS 115 S. CENTRE ST.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5 May 1966	
23c. NAME OF CEMETERY OR CREMATORY Potomac Valley Park		23d. LOCATION (City or Town) (County) (State) Keyser, Mineral W. Va.	
24. FUNERAL DIRECTOR Allen M. Potomac		25. REGISTRY BY REGISTRAR MAY 16 1966	
26. REGISTRAR'S SIGNATURE Charles Judge			

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ENTRANCE OF DEATH

ALLIED

KEYSET

2 DAYS

CHIEF

WESTERN HOSPITAL

W. A. A. H. H.

CHODAKER

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9-11-1963

WHITE

WIRIWA

10-10-1963

IDA JOHNSON

JAMES CHURCH

MEMORIAL HOSPITAL, CHICAGO, ILL.

Dr. A. J. MURKIN

11-2-1963

MAY 18 1963

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06292

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06288

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oldtown		c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oldtown 01-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At Home				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roy Middle Alonzo Last Shryock, Sr.				4. DATE OF DEATH Month MAY Day 10 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1896		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 Year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Rubber Worker--Kelly Springfield		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Lunda T. Shryock				14. MOTHER'S MAIDEN NAME Florence Athey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-07-5299		17. INFORMANT Mrs. Mary Shryock Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CORONARY SCLEROSIS DUE TO (c) ---						INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic M.D. EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED May 11, 1966 Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 13, 1966		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Park		23d. LOCATION (City or Town) (County) (State) Near Cumberland, Md.	
24. FUNERAL DIRECTOR John J. Hafer ADDRESS 230 Balto Ave., Cumberland, Md.				25a. REC'D BY REGISTRAR MAY 12 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
c. LENGTH OF STAY IN 1b 2 DAYS		d. STREET ADDRESS 487 GOETHE ST.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ADA JONES SMITH		4. DATE OF DEATH Month Day Year MAY 12 1966	
SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-12-07
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) OAKLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BASHOR CROSS		14. MOTHER'S MAIDEN NAME MARY TAYLOR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Ira T. Smith		PATIENT'S CHART 487 Goethe St. Cumb'd Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1 Right heart failure DUE TO (b) 2 Acute + chronic Cor pulmonale due to DUE TO (c) extreme obesity and Bronchitis, acute		INTERVAL BETWEEN ONSET AND DEATH 1 week 10 yrs 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive and arteriosclerotic cardiovascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/10/66 , 19 48 , to 5/12/66 , 19 66 , that (I) (we) last saw the deceased alive on 5/10/66 , and that death occurred at 7:30 AM , from causes and on the date stated above.			
22a. SIGNATURE S. G. WEISMAN		22b. DATE SIGNED 5/14/66	
22c. PHYSICIAN'S NAME (Type) S. G. WEISMAN MD		22d. ADDRESS 59 GREENE ST CUMBERLAND, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 15, 1966	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md	
24. FUNERAL DIRECTOR John J. Hafa		25a. REC'D BY REGISTRAR MAY 16 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 230 Baltimore Ave., Cumberland, Md	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DEATH CERTIFICATE

0000

300 Madison Ave., New York 17, N.Y.
MAY 10 1966
100-111111-111111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be removed and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
06294 CERTIFICATE OF DEATH 06290										
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND Barton					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS ALLEGANY COUNTY INFIRMARY			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First JANET Middle EDGAR Last SMITH					4. DATE OF DEATH Month MAY Day 13 Year 66					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-6-1888		9. AGE (In years last birthday) yrs. 78		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY OWN HOME			11. BIRTHPLACE (County & State, or foreign country) BARTON, MD.			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM SMITH					14. MOTHER'S MAIDEN NAME MARGARET SHAW					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO. NONE		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 7051 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Severe Widespread Erythema Multiforme Bullosum DUE TO (c) 12 days								INTERVAL BETWEEN ONSET AND DEATH 2 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 4 May, 1966 to 13 May, 1966 , that (I) (we) last saw the deceased alive on 13 May, 1966 , and that death occurred at 9:50 A.M. from causes and on the date stated above.										
22a. SIGNATURE DR. MARK M. KROLL					22b. DATE SIGNED 14 May 1966			22c. PHYSICIAN'S NAME (Type) DR. MARK M. KROLL		
22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.										
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF MAY 15, 1966		23c. NAME OF CEMETERY OR CREMATORY LAUREL HILL CEMETERY			23d. LOCATION (City or Town) (County) (State) MOSCOW, MD.		
24. FUNERAL DIRECTOR BYRON KIGHT CUMBERLAND, MD.					25a. REC'D BY REGISTRAR MAY 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

1934

1934

STATE OF TEXAS

AT ELM

CHANDLER

DAY

CHANDLER

MEMORIAL HOSPITAL

SMITH

EDWARD

JANET

EMMA WHITE

8

1-1-1934

HARTMAN, MT.

WILLIAM SMITH

ARRIVED 2:30

MEMORIAL HOSPITAL - ELM

WILLIAM SMITH

WILLIAM SMITH

WILLIAM SMITH

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WILLIAM SMITH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

M

06295

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06291

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 605 VIRGINIA AVE.	
3. NAME OF DECEASED (Type or print) First Middle Last EDITH M. SPEELMAN		4. DATE OF DEATH Month Day Year MAY 17 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/84
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY PAXTON		14. MOTHER'S MAIDEN NAME ANNIE BOCKER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Congestive Heart Failure DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 18 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1966 , 19 1966 , 19 1966 , that (I) (we) last saw the deceased alive on May 17 19 66 , and that death occurred at 2:50 PM from causes and on the date stated above.			
22a. SIGNATURE Dr. G.O. Himmelwright		22b. DATE SIGNED 5/19/66	
22c. PHYSICIAN'S NAME (Type) DR. G.O. HIMMELWRIGHT		22d. ADDRESS 133 VIRGINIA AVE. CUMBERLAND, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/20/66	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memo. Ph. Cumb. Md.		23d. LOCATION (City or Town) (County) (State) Cumb. Md.	
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.		ADDRESS 133 VIRGINIA AVE. CUMBERLAND, MD	
25a. REC'D BY REGISTRAR MAY 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

00293

CENTRAL OF DE

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MEMORIAL HOSPITAL

2 DAYS

CUMBERLAND

100 VIRGINIA AVE.

ERIN M. SPELMAN

MAY 15

FEMALE WHITE

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B.V.

ANNIE BOKER

HENRY BAXTON

MEMORIAL HOSPITAL, CUMBERLAND, MD.

DR. D. P. HENDERSON

100 VIRGINIA AVE. CUMBERLAND, MD.

MAY 22 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06296					06292				
1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 5/13/1966 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Allegany County Infirmary					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mt. Savage d. STREET ADDRESS New Row e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Harriet Ann Thoerig			4. DATE OF DEATH Month Day Year May 19, 19 66						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/2/1887		9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Mt. Savage, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph T. Jenkins					14. MOTHER'S MAIDEN NAME Gurtha Virginia Calcasser				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT P.O. Box 599, Cumberland, Md. Allegany County Infirmary records.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic degenerative 4214 DUE TO Endo Carditis, Chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerosis, Atherosclerosis DUE TO (c) Chn. Osteoarthritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 5/13/66 , 19, to 5/19/66 , 19, that (I) (we) last saw the deceased alive on 5/19/66 , 19, and that death occurred at A. M, from the causes and on the date stated above.									
22a. SIGNATURE Lee B. Mathews			at 9:20 A.M. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 5/19/1966			
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M. D.			22d. ADDRESS 49 Greene St., Cumberland, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 5-21-1966		23c. NAME OF CEMETERY OR CREMATORY St. George - Episcopal		23d. LOCATION (City, town or county) (State) Mt. Savage Md.		
24. FUNERAL DIRECTOR Joseph R. Dunsen			ADDRESS Greensburg, Md.		25a. REC'D BY REGISTRAR MAY 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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Allegany

University

12/13/55

Mr. Savage

Allegany County, Maryland

New York

Replied

Threat

May 15

James White

X

4/2/57

70

Honorable

Mr. Savage, Maryland

Joseph T. Sullivan

George Virginia University

P.O. Box 502

Allegany County, Maryland

2/13/55

2/13/55

2/13/55

at 9:30 A.M.

X 2/13/55

Mr. B. Sullivan, N. D.

Mr. Green, N. D., Cumberland, Md.

MAY 23 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
06297					06293						
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG			c. LENGTH OF STAY in lb LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 94 W. MECHANIC STREET					d. STREET ADDRESS 94 W. MECHANIC STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ROBERT THOMPSON					4. DATE OF DEATH Month MAY Day 24 Year 19 66						
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 9, 1899		9. AGE (In years last birthday) yrs. 66			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER			10b. KIND OF BUSINESS OR INDUSTRY CITY OF FROSTBURG		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JAMES THOMPSON					14. MOTHER'S MAIDEN NAME LUCY LAFFERTY						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO			16. SOCIAL SECURITY NO. 217-10-5185A		17. INFORMANT Address MRS. ROBT. THOMPSON, FROSTBURG, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Hypertension DUE TO (c) Arterio-sclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201										INTERVAL BETWEEN ONSET AND DEATH Sudden 5 yrs. 5-6 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5-10 , 19 66 , to 5-24 , 19 66 , that (I) (we) last saw the deceased alive on 5-23 , 19 66 , and that death occurred at 6:40 A.M. from causes and on the date stated above.											
22a. SIGNATURE H. C. Diehl					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-25-66				
22c. PHYSICIAN'S NAME (Type) H. C. DIEHL, M. D.					22d. ADDRESS W. MAIN ST., FROSTBURG, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 26, 1966		23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEMORIAL PARK			23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.				
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.					ADDRESS		25a. RECEIVED BY REGISTRAR DATE MAY 26 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

OFFICE OF THE DIRECTOR

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and it will be sent within 72 hours after death.

2

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06298

06294

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hosp.</u>		d. STREET ADDRESS <u>390 McHenry St.</u>	
3. NAME OF DECEASED (Type or print) <u>James Walker</u>		4. DATE OF DEATH <u>May 6, 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 5, 1878</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Supt. of Production</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Mill</u>	
11. BIRTHPLACE (State or foreign country) <u>Ceres, Fifeshire, Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Walker</u>		14. MOTHER'S MAIDEN NAME <u>Isabella Hutt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>A 109-01-4663</u>	
17. INFORMANT <u>Mrs. Josephine M. Walker</u>		Address <u>390 McHenry St. LaVale, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>CORONARY SCLEROSIS</u> (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>---</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 5/6/66	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Rt. # 9 Cumb. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/9/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Md.</u>	
24. FUNERAL DIRECTOR <u>H. Wayne George</u> ADDRESS <u>Cumberland, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 10 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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48370

MAY 10 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLERSLIE		c. LENGTH OF STAY IN 1b 10 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLERSLIE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last ROBERT A. WILLIAMS				4. DATE OF DEATH Month Day Year MAY 27 19 66			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 11, 1891	
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) ALTOONA, PA.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC				10b. KIND OF BUSINESS OR INDUSTRY PENNA. ELECTRIC CO.		11. BIRTHPLACE (County & State, or foreign country) ALTOONA, PA.	
13. FATHER'S NAME IRA J. WILLIAMS				14. MOTHER'S MAIDEN NAME FRANCES KIRKPATRICK			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 194 09 0235		17. INFORMANT MIRIAM WILLIAMS, ELLERSLIE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute C.V.A. 4200 DUE TO (b) Chr. C.A.D. with Insufficiency DUE TO (c) Chr. A.S.H.D. with Hypertension CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this-hospital) attended the deceased from June 1958, to May 27, 1966, that (I) (we) last saw the deceased alive on May 20, 1966, and that death occurred at 7 P.M. from the causes and on the date stated above.							
22a. SIGNATURE John C. Topper				22b. DATE SIGNED May 31- '66		22c. PHYSICIAN'S NAME (Type) JOHN TOPPER, M.D.	
22d. ADDRESS HYNDMAN, PA.				22e. REC'D BY REGISTRAR JUN 6 1966			
22f. REGISTRAR'S SIGNATURE Charles Judge				23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			
23b. DATE THEREOF MAY 31, 1966		23c. NAME OF CEMETERY OR CREMATORY REST LAWN MEMORIAL GARDENS		23d. LOCATION (City, town or county) (State) CUMBERLAND, MD.			
24. FUNERAL DIRECTOR BYRON KIGHT				CUMBERLAND, MD.			

65303

CERTIFICATE OF DEATH

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JUL 11, 1901

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06300					CERTIFICATE OF DEATH			06296	
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 23 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, 01-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS 424 FRANKLIN ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HILDA KATHLEEN WILLISON					4. DATE OF DEATH Month Day Year MAY 12, 19 66				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-1-1901		9. AGE (In years lost birthday) yrs. 65	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TEACHER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Murleys Branch near CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME MOSES HANSON WILLISON					14. MOTHER'S MAIDEN NAME ROSE CHANEY				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1992 METASTATIC CARCINOMA DUE TO (b) ORIGON- LIVER OR SPLEEN ? DUE TO (c) 1992 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									INTERVAL BETWEEN ONSET AND DEATH 3-4 MOS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PAGETS DISEASE									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/19/66 , 19 to 5/12/66 , that (I) (we) lost saw the deceased alive on 5/11/66 19, and that death occurred at 4:30 AM M, from causes and on the date stated above.									
22a. SIGNATURE <i>Thomas F. Lusby</i>					22b. DATE SIGNED 5/12/66		22c. PHYSICIAN'S NAME (Type) DR. THOMAS F. LUSBY		
22d. ADDRESS 932 NATIONAL HIGHWAY									
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 15, 1966		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park			23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md		
24. FUNERAL DIRECTOR John J. Hafer					25a. REC'D BY REGISTRAR MAY 16 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
230 Baltimore Ave. Cumberland Md									

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

06302

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06297

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. #2 Flintstone</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. #4 Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Williams Rd.</u>		d. STREET ADDRESS <u>Fairview Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Thomas</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> , Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/22/08</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	9. AGE (In years last birthday) <u>57</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Mt. Savage, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis W. Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Mazie E. Robinette</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-24-0556</u>	
17. INFORMANT <u>Mr. Harry R. Wilson</u>		Address <u>Balto Pike Cumb., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>4201</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Coronary Sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>----</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		22. DATE SIGNED <u>May 5, 1966</u>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/8/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Meadow Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>nr. Cumberland, Md.</u>
24. FUNERAL DIRECTOR <u>H. Wayne George</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Cumberland, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAY 10 1966</u>			

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RECEIVED DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S REPORT OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

M				Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06302				CERTIFICATE OF DEATH				06298			
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND								2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 11 DAYS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL								d. STREET ADDRESS RT. #4, BOX 205,				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last HERVEY F. ZIMMERLY								4. DATE OF DEATH Month Day Year MAY 13, 19 66.											
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-28-1881		9. AGE (In years birthday) yrs. 84		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm				11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.				12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME GEORGE ZIMMERLY (Zimerly)								14. MOTHER'S MAIDEN NAME URSULA STALLINGS											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 218-34-2691				17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4330 IMMEDIATE CAUSE (a) Cardiac Arrest (b) Arrhythmogenic Cardiac under Stress (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from June, 19 65, to 5/13, 19 66, that (I) (we) last saw the deceased alive on 5/12, 19 66, and that death occurred at 8:00 AM, at home and on the date stated above.																			
22a. SIGNATURE William P. James								M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/12/66									
22c. PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES								22d. ADDRESS 441 N. CENTRE ST., CUMBERLAND, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF May 16, 1966		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery				23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany									
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.								25a. REC'D BY REGISTRAR DATE MAY 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge									

